ALCOHOLISM AND DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

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The Journal

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Michael: new objectives

Canadian CoAs on the move

By Karin Maltby

TORONTO — A Canadian association for children of alcoholics of all ages has been launched here.

The Canadian Association for Children of Alcoholics (CACOA) will be both a resource for helping professionals and a group to seek accessible community services for children living in alcoholic homes and those who have left.

Kathleen Michael, an Addiction Research Foundation therapist and consultant here and now also vice-president of CACOA, told **The Journal** there are three main objectives for the association:

- to increase public and professional awareness, understanding, and recognition of the needs of children of alcoholics (CoAs) of all ages through involvement of the entire community. This will be done through a network to promote information exchange and resources and to advocate funding from public and private sources;
- to advocate accessible services addressing the special problems arising from being a CoA (**The Journal**, June, 1985), including support for professional training, for professionals who are themselves CoAs, and for school-based programs that address the needs of CoA youth and protect their right to live in a safe and healthy environment; and,
- to help existing programs initiate primary and comprehensive services for CoAs, staffed by professionals specifically trained to meet their needs, as well as on a broader basis to encourage clinical and genetic research.

CACOA, now federally incorporated as a non-profit organization, drew more than 200 delegates from

(See Canada, p3)

Ottawa Charter pushes for global alliance on public health

By Anne MacLennan

OTTAWA — In November, 1986, 210 people from around the globe were deep in a week-long series of discussions on health.

It was the first International Conference on Health Promotion in Industrialized Countries, subtitled: The move toward a new public health.

In attendance were the key figures behind a still young and frequently misunderstood movement toward achieving health for all by the year 2000, an ambition which evolved internationally through the World Health Organization (WHO).

The WHO was a co-sponsor of the meeting here, along with Health and Welfare Canada and the Canadian Public Health Association.

Health promotion posits there are fundamental prerequisites for improvement in health: peace, shelter, food, income, a stable eco-system, sustainable resources, social justice, and equity.

Furthermore, political, economic, social, cultural, environmental, behavioral, and biological factors can favor health, or be harmful to health; health promotion action aims at making these conditions favorable through advocacy.

Says J. E. Asvall, MD, WHO regional director for Europe: Health for all is a very ambitious, broad, social movement that forces countries to face to what extent they really are solving their health problems, whether they are marshalling all resources, and whether they are searching for imaginative, new strategies for improving health.

Some delegates here, relative newcomers to the debate, struggled: What is health promotion? What does it have to do with us — we're healthy? Doesn't it have more to do with Bangladesh than England? Or Canada?

But by the end of the week, there was consensus and an "Ottawa Charter for Health Promotion," the second of its kind in history.

In it, conference participants pledge to:

- move into the arena of healthy public policy and to advocate a clear political commitment to health and equity in all sectors;
- counteract the pressures toward harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition, and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- acknowledge people as the main health resource, to support and enable them to keep themselves, their families, and their friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions, and well-being;
- re-orient health services and their resources toward the promotion of health, and to share power with other sectors, other disciplines, and, most importantly, with people themselves; and,
- recognize health and its maintenance as a major social investment and challenge, and to address the overall ecological issue of peoples' ways of living.

"The conference urges all concerned to join them in their commitment to a strong public health alliance."

R.A. (Ron) Draper on health promotion and addictions p5

Responsibility split a barrier

By Elda Hauschildt

TORONTO — Marc Lalonde, author of the ground-breaking report that changed the public health field 12 years ago, says his recommendations have been held back by the federal/provincial split in health care responsibility in Canada.

Lalonde: facing facts

"When it comes to impacting on health and wellness, particularly on any aspect affecting environment, there is a difference in terms of responsibility in this country, and also a division of responsibility within governments," Mr Lalonde told 500 delgates here at the Wellness 86 conference.

Federal health minister from 1972 to 1976, Mr Lalonde was the featured speaker on an opening panel discussion which traced the evolution of the wellness movement. Other speakers referred repeatedly to the 1974 Lalonde Report, *A New Perspective on the Health of Canadians*, as the cornerstone of the movement.

"In a federal system — in the United States as well as in Canada — health care responsibility is divided. We had to face this fact very quickly in trying to apply some of the recommendations in *New Perspectives*," said Mr Lalonde.

He cited car-seatbelt legislation as an example: "First of all, such legislation is a provincial responsibility. There was nothing the federal government could do but convince.

"So, I called a meeting of (provincial) health ministers . . . and very quickly, we agreed

(See New, p2)

People use drink/drugs to make life 'interesting'

By Terri Etherington

TORONTO — Alcohol and other drugs are just ways of making life more interesting, says Ken Lowe, president of Action Studies Institute, Calgary.

"Intoxication is primarily a recreational activity, and we make a terrible mistake in so many prevention activities in assuming people use drugs or alcohol as a means of solving problems," he told the 4th annual Drug Education Coordinating Council conference here.

"The vast majority of people who use drugs or alcohol are not attempting to solve problems, they are simply attempting to make life interesting."

See Exposure, p4

Mr Lowe said the human mind can stand anything but boredom. "Boredom is a lack of change. You're different after you've had a beer than before. . . . And, if you want to be really different, have eight beers."

Intoxication is one of the 11 most popular free-time activities, things people choose to do when not being constrained to do something else.

And, Mr Lowe said, the interesting thing about these 11 universal activities is that they are so easy to do; four, or five, or six can be done at the same time.

One of the reasons young people are so attracted to smoking, for instance, is that it is one of the few adult behaviors and prerogatives kids can copy very easily, Mr Lowe said.

INSIDE

NEWS

Briefly . . .

Those paternal GPs

LONDON — Doctors don't give patients enough information about why they prescribe drugs and how to take them, says the British mental health association *Mind*. A new consumer guide published by the group says GPs either adopt a paternalistic attitude to their patients or are simply too busy to explain, says *Doctor*.

Blue Lightning

BRACEBRIDGE, Ont — A coroner's jury here has recommended that windshield washer fluid be labelled with a warning it may cause blindness or death if swallowed. The jury was investigating the death of a prisoner who drank a concoction called Blue Lightning, made from the fluid, reports *The Globe and Mail*.

The best-kept secret

PITTSBURGH — Sexual addiction remains behind closed doors, says the Gateway Rehabilitation Center here. Patrick Carnes, PhD, who conducts seminars on the subject at the centre, says the sexual addict abuses sex the same way an alcoholic abuses alcohol. The four-step cycle, he continues, is preoccupation with sex, ritualization, compulsive sexual behavior, and despair.

Bytes get bitten

TORONTO — Five people who work for the Liquor Control Board of Ontario have been convicted of stealing $100,000 worth of inventory. And in addition, another $605,000 worth of missing inventory is the result of paper error, computer tape problems, and book entries . . . data input errors, or problems related to procedural error, Consumer Minister Monte Kwinter said in *The Toronto Star*.

Wild grey yonder

TORONTO — The Canadian Cancer Society is stepping up its anti-smoking campaign with an appeal for a ban on smoking on all commercial flights in Canada. Ken Kyle, a society spokesman, told *The Toronto Star*: "The feeling we get from some of the larger airlines is that if the government would take some leadership and would pass some regulations, they would fully cooperate."

A trade off

KINGSTON, Ont — Since prisoners at Joyceville Penitentiary here are being tested for drug use, there's now a new commodity on the prison's black market: drug-free urine, reports *Canadian Press*. "Somebody had a pretty good scam going," Dennis Curtis, a prison spokesman, said. Urine was bartered for cigarettes until guards caught on and stopped the trading. Officials believe the 'clean' urine was sold for three packages of cigarettes, one pack being a returnable deposit if the urine container was returned.

ARF: 10% to 15% have alcohol/drug problems

Injured workers need addiction help

By Terri Etherington

TORONTO — As many as 10% to 15% of injured workers have some measure of alcohol or other drug problems, says the Addiction Research Foundation (ARF) here.

If not assessed and treated, these problems may impede recovery, and workers may return to the job site at high risk for other accidents.

In a brief to the Ontario Task Force on the Vocational Rehabilitation Services of the Workers' Compensation Board (WCB), the ARF recommends several steps to assess and treat injured workers before they go back to work.

The brief points out statistics in Canada and the United States show clearly that alcohol and other drug use increases the risk of accidents.

"This suggests we can expect to find (these) problems among injured workers to a greater extent than they exist in society at large."

The ARF recommends a more open process of identifying and assessing alcohol and other drug problems among injured workers as soon as possible after the worker becomes involved with the WCB. However, the ARF says, policy framework must ensure admission or identification of drug-related problems would not influence compensation claims.

Injured workers, says the ARF, are one group at high risk of developing alcohol- and drug-related problems. "Since they are already in contact with health and social science professionals, they are in an excellent position to be assisted."

Existing screening and diagnostic tools could be used by WCB staff and/or private physicians treating injured workers.

Training of staff at the WCB Downsview hospital to conduct alcohol/drug assessment and to make appropriate referals is also recommended.

The ARF provides treatment assistance on an inpatient residential service or through day treatment and outpatient counselling and can provide advice to attending physicians on the careful management of pain with minimum narcotic doses and on withdrawal of the drugs, says the brief.

Cooperation key to good prevention

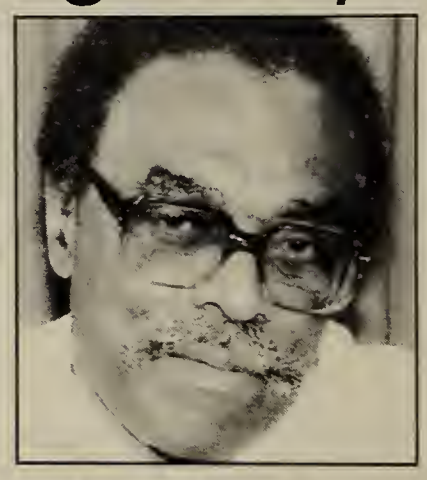
By Terri Etherington

TORONTO — For youth, their parents, teachers, community workers, and helping professionals, the message is clear: cooperative action and pragmatic planning are the way to fight alcohol and other drug abuse.

Addiction Awareness Week in Ontario in November culminated in a two-day conference designed to point the way for future action and to give participants tools to counter drug abuse in their home communities.

Ontario Health Minister Murray Elston said the Drug Education Coordinating Council (DECC), sponsor of the conference, "is an excellent example of how community-based organizations, both public and private, can join together and tackle major health care concerns in a way that is decentralized yet coordinated."

Elston: message gets out



Alexander: life 40 years back

The message, said Mr Elston, "is getting out."

He pointed to the steady decline in the number of drinking drivers killed in Ontario, falling to "its lowest point on record" in December, 1985.

The province's commitment to fighting the problems of alcohol and other drug abuse continues, he said, as evidenced by increased funding for public health units, which include drug and alcohol abuse prevention in their services, and increased funding of community-based addictions programs (**The Journal**, January, 1986).

Mr Elston: "This new policy puts community-based treatment programs on the same financial basis as those run by institutions. It removes the need for client fees. It reflects the growing body of research that attests to the effectiveness of community-based programs and will help promote access to those services for all the people of the province."

Lincoln Alexander, Ontario's Lieutenant-Governor, said the fight against drug abuse should be "a firm attack, a strong attack, a continual attack."

When he visits schools he carries the message to young people: "Think of me 30, 40, 50 years ago and think about what life was like in terms of being tough . . . and I never turned to alcohol and drugs.

"Life never has been easy and never will be easy. It is not fair, and it will never be fair."

New federal framework lacks detail: Lalonde

(from page 1)

this was indeed a good idea. Then, they had to go back home and face their ministers of justice, attorneys-general, ministers of highways."

It took a very long time for legislation to be passed.

Other factors have also affected the implementation procedure, Mr Lalonde said: the nature of the change in lifestyle demanded by the report, the resistance of "powerful and well-financed" special interest groups, and the long time-delay before people can actually see the positive impact of wellness.

"I think there have been some significant developments over the past 12 years though," he added.

"And, I don't think they are all the result of *New Perspectives* by any means. *New Perspectives* came at the right moment and was more or less the result of what was already happening in the country. It only served as a stimulus and framework for all kinds of groups, agencies, government action, and for raising the level of consciousness of Canadians.

"Whether we look at human biology generally, environment, lifestyle, or health services themselves, I think we will find a lot has taken place."

Mr Lalonde said he was "frankly disappointed," however, by the recent report issued by Health Minister Jake Epp, *Achieving Health for All — A Framework for Health Promotion* (see page 5).

"Not that I quarrel with any of the principles contained in the paper, but I had expected that after all the time that has elapsed and all the studies that have been made, we would have had a lot more of a specific plan for action from the government.

"The statement reads like something that was written before *New Perspectives*, not 12 years after."

Mr Lalonde referred specifically to a "long list" in the Epp report of policies having a direct bearing on health that need to be coordinated: income security, employment, education, housing, business, agriculture, transportation, justice, and technology, among others.

"To try to coordinate all those various activities, and between the federal and provincial governments also, is an immense task.

"There is no way — no way — any government will hand over to any particular minister of health, provincial or federal, all that power. It would be more or less handing the whole government over to the minister of health."

— coming up in —

THE JOURNAL

- **RCMP Drug Intelligence Estimate**

Elston says largest killers avoidable

Ontario backs health promotion

By Elda Hauschildt

TORONTO — Health promotion should be the cornerstone of government policy making, of the thinking of health care professionals, and of people's attitudes to their own health, says Ontario Health Minister Murray Elston.

"We have to tell people that today's largest killers — heart and stroke disease, cancer, lung disease, car accidents, cirrhosis of the liver — are avoidable," he told 500 delegates here at the Wellness 86 conference.

"We know most of the health gains in the last half-century, such as the virtual elimination of polio, diptheria, tuberculosis, and smallpox, have been achieved through a combination of health promotion and disease prevention."

Mr Elston quoted Milton Terris, MD, (**The Journal**, May, 1984) who estimates "with a reasonable deployment of our present resources for prevention, and with our existing scientific knowledge of how to achieve health, we could by the year 2000 accomplish the following:

- a 70% reduction in heart disease and stroke,
- a 15% reduction in cancer,
- a 20% reduction in chronic obstructive lung disease,
- a 30% reduction in accidents, poisoning, and violence, and
- a 40% reduction in cirrhosis of the liver."

Mr Elston also announced the names of members of the panel who with chairman Robert Spasoff, MD, of the University of Ottawa will develop a document setting health goals for Ontario.

The minister noted the goal-setting process will be consultative and that a conference on health promotion in the province will be held next spring.

CHILDREN OF ALCOHOLICS

CoA organizations need funding, structuring

By Karin Maltby

TORONTO — Euphoria about the burgeoning growth of the children of alcoholics movement in the United States and Canada must be tempered with awareness that action among mental health professionals is "no sure thing."

Psychiatrist Timmen Cermak, chairperson of the US National Association for Children of Alcoholics (NACoA), told a conference here the only way to ensure help for children of alcoholics is to "buckle down and create organizations which are well-funded, well-structured," and which will still be in existence for decades to come.

Dr Cermak addressed more than 200 delegates to the first national meeting here of the Canadian Association for Children of Alcoholics (CACOA). He warned them they must work to help young children living in alcoholic homes, "locked away in silence and isolation and who need an organization to speak for them" (see related story, page 1).

Dr Cermak estimates three million children of alcoholics — of all ages — live in Canada, basing his figure on the 28 million people affected in the US, and dividing that figure proportionately to Canada's population.

"It's dangerous to your health to have an alcoholic parent," he said, citing increased risk of fetal alcohol syndrome, hyperactivity, attention-deficit disorders, attempted or completed suicides, and, "perhaps, most ironic, increased risk of early alcohol and other drug abuse."

And, while adult children can begin recovery because they have physically left their alcoholic environment, young children especially "need our help. They can't walk out of the house. They can't support themselves or join organizations," Dr Cermak said.

"Our goals by starting organizations like NACoA and CACOA must be to begin offering a voice for young children of alcoholics, to begin raising public awareness."

Dr Cermak said mental health professionals treat children of alcoholics but are unaware of the root cause of the illness, as are foster parents and the legal system.

He stressed the need for better education about chemical dependency among all professionals dealing with troubled children.

"We need to bring effective services to bear . . . . We all need to start being nuisances. Any treatment centre which says it has a family program but doesn't include age-appropriate treatment for all children is not a family program."

Services must also be available in the schools, he said, mentioning model, confidential, student-assistance programs already begun in the US and based on the format of employee assistance programs.

Dr Cermak: "My hope is that 100 years from now, most children won't understand (what it is like) to be alone with an alcoholic parent and have no place to go."

McIlwain: president

Cermak: no place to go

Denis: on board

Margaret Cork named first honorary member

TORONTO — A pioneer in children of alcoholics research says history has been made in Canada with the formation of the Canadian Association for Children of Alcoholics (CACOA).

Margaret Cork, author of the landmark book, *The Forgotten Children*, told the 1st national conference on children of alcoholics here "at least we've made a start."

Cork: pioneer

Ms Cork, now retired, wrote her book in 1969 while at the Addiction Research Foundation here. She thanked organizers of CACOA for their determination to help children of alcoholics and remarked that Kathleen Michael, ARF therapist and family consultant and now also CACOA vice-president, had the "zeal, enthusiasm, and vision" for what might be achieved in Canada.

"All children are hurting," Ms Cork said. "But, at least for this particular group, we've made a start" (The Journal, May, 1985).

Ms Miehael presented an award to Ms Cork which establishes her as the first honorary member of CACOA, "in recognition of her contribution to children of alcoholics."

Canada lagging behind US in attention to CoA issues

(from page 1)

across the country, to its first national conference.

Timmen Cermak, a psychiatrist and chairman of NACoA (the United States National Association for Children of Alcoholics) told the meeting: "What CACOA needs from you most is money. They need you to join, not because it's going to do anything great for you, but because it's going to be your contribution to the solution."

And, Elizabeth Miller, a member of the conference planning committee, said, "We need your assistance in spreading the information concerning the importance of CoA issues in schools, in homes, in the workplace, in the penal system, in hospitals, and in alcoholism treatment centres and programs.

"In the US, there is a growing understanding and awareness of these issues. But, in Canada, except for a few locations, there is little recognition or knowledge of this population. There is much work to do and, right now, too few qualified and informed people to carry it out."

Ms Miller said insufficient resources have limited CACOA's growth in its first year to identifying available resources, working with them, and initiating and supporting plans to find more help for CoAs. Active promotion should be carried out so that all Canadians are aware of CoA issues.

CACOA's administrative board of directors includes founding directors: Diane McIlwain, employee assistance program coordinator, American Express Canada, Inc, president; Kathleen Michael, vice-president; Ann Denis, therapist and consultant, Experiential Learning Associates, Toronto, treasurer; and, Diane Davies, manager, employee advisory resource, Control Data, Toronto.

Four other directors will be chosen from the Atlantic, Quebec, Prairie, and Pacific regions. Four general directors will complete the board.

For more information on CACOA, contact **The Journal**, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1.

INSIDE OUT

A pilot for complicated waters

When I came out of the hospital, after the Fall, and returned to the world with its suddenly lonely streets, one of the most bitter things I had to face, immediately and head on, was the certain knowledge of my overwhelming ignorance.

The Fall had left me without any moats and high walls; my egotism and arrogant superiority, which had only served to make my catastrophe more pronounced when it happened, were revealed for what they had always been: frightening illusions, compelling for their grotesque, smoke-and-mirror irrelevancy.

All the props and all the tricks of the trade were swept away; all of my experience and my intelligence and my instincts were impotent in dealing now with what had happened to me. All ideas of my life as a slightly romantic journey into progress and growth were rendered absolutely empty.

You see, the Fall burns it into your being that you are now back at the ultimate square one, and all bets are off.

To realize in the deepest regions of your heart that you have been systematically lying to yourself, murdering your potential, and short-changing other people for years because of your addiction is to stand in squalid isolation, utterly exposed and humiliated and ashamed and almost beyond any zones of forgiveness.

It does not help much, either, when people tell you that what you have is merely a disease, or at least I should tell you it certainly didn't help me at the time of the Fall.

Because always nagging, always insisting, always pointing its truthful finger at you, is the reality that being addicted is nothing like having diabetes, or epilepsy, or multiple sclerosis.

. . . It could have been the longest and worst time of my life

No, being addicted is a disease, all right, a physical disease that has great moral implications, a *dis-ease* of the soul.

So there I was, out of the hospital and not only trying to put the pieces back together, but also having trouble finding out where the pieces had disappeared.

It seemed useless to talk to friends about what I was going through, because the experience was, in an eerie way, beyond words.

The literature on addiction I absentmindedly flipped through pointed out a few signposts. But, I had no energy to concentrate on what it was saying, and what I could focus on was either too technical or too evangelical in tone.

And, there were still six weeks to go before I entered the clinic, six weeks that could have been the longest time of my life, the worst, too. Except for one welcoming light.

A book helped me a little then, and helped me much, much more after I got out of the clinic and was not only finding the pieces again, but also putting some of them back together.

Since then, I have read this book four times. I have compared it to other works on what addiction means, and it can serve, I humbly suggest, very well indeed as a pilot to steer a passage through some very complicated waters for people who were, or are, in the boat I was in at the time of the Fall.

I think — and you know I am only a layman, so I hope you will be tolerant — that the book, *The Road Less Travelled*, would be of use to alcoholics and other addicts whose eyes are beginning to clear enough to be able to see possibilities for changing their lives.

The book was written by Scott Peck, a United States psychiatrist, and published in 1978.

It has since become a phenomenon in these dreary, yuppie days because it doesn't offer quick roads to happiness, or any cheap comforts.

In fact, it steadfastly, resolutely, and defiantly flies in the face of our narcissistic, self-absorbed times and demands that we be brave, disciplined, and convinced a full life is bound to be full of pain and we shouldn't try to avoid it.

The book talks about the necessity of delaying gratification, the need for restraint and balance in our lives, and avoiding procrastination and other not-so-sweet pills.

Now, Dr Peck isn't offering anything that will astound you with its novelty. His ideas are not new tablets brought down from a mountain top, as he is the first to admit.

But, what he is saying goes so against the grain of our culture that *The Road Less Travelled* almost appears revolutionary these days.

And, what he is saying has particular relevance to the situation of addicted people and, perhaps, to those who are trying to help those who are addicted.

All I know is that for one man wrestling with reality at a very bad time of his life, the book was like having a small flashlight in his shaky hand in a dark and dangerous forest.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Infant apnea tied to drug-using moms

Abnormal breathing patterns have been documented in sleeping infants born to drug-using mothers. And, the California researchers who conducted the study speculate these abnormalities may contribute to the substantially increased risk such infants have of succumbing to sudden infant death syndrome. In research based at the Infants of Substance-Abusing Mothers (ISAM) clinic at Los Angeles County-University of Southern California Medical Center, Los Angeles, 28 pneumograms were obtained from 27 such infants. Pneumograms consist of a recording of the chest-wall impedance respirations and an electrocardiogram (ECG) recorded for 12 hours overnight. Results were compared with those obtained from 43 control infants. Mothers of the children in the study were identified as either users of opiates, cocaine, or PCP, or as polydrug abusers. Results show children born to these mothers had a longer total sleep time, greater durations of apnea, a higher total duration of apneas greater than or equal to six seconds, more periodic breathing, a higher mean respiratory rate, and a lower mean heart rate. Overall, 32% of the pneumograms of these infants were abnormal compared with 9.3% of the control pneumograms. As all but one of the children with drug-using mothers who had abnormal readings were two months of age or younger, the study says this suggests abnormalities may be the result of an effect of *in utero* drug exposure that decreases with time.

American Journal of Diseases of Children, October, 1986, v.140:1015-1020.

Passive smoking studies flawed

Misclassification cannot be used as a defence by those who claim findings on the dangers of passive smoke have been exaggerated. That is the conclusion of A. Judson Wells from Delaware after evaluation of some of the statistics involved. He says one potential flaw of estimates of up to 1,800 lung cancer deaths from passive smoking annually in the United States is the possible misclassification of smoking spouses as non-smokers. Another, he points out, is that in many studies, smoking status is established by interviews or questionnaires, not hospital charts, which some scientists believe may be unreliable. Other findings, he adds, do not confirm the assumptions of one researcher that 5% of smokers represent themselves as non-smokers. "Miclassification," he concludes, "is not a justifiable refuge for those who feel uncomfortable with the thought that passive smoking is associated with appreciably higher death rates from lung cancer and heart disease."

The Lancet, September 13, 1986, No.8507:638.

Drunk driver injuries more traumatic

Alcohol can be a deadly addition to any equation involving injury, statistical research from North Carolina shows. The drinking driver is more likely to suffer serious injury or death than the non-drinking driver, no matter what other variables are taken into account. Using data from the North Carolina Traffic Accident Report Forms, the North Carolina Driver History File, and state medical examiner reports on deceased victims of crashes, the research team studied more than one million drivers involved in motor vehicle crashes. Taking into account damage to the vehicle and the type of accident, the data shows drinking drivers were almost four times as likely to be killed in a crash. This proportion was even greater for accidents of lesser severity. Similar statistics are shown for drivers seriously injured in auto accidents. Even when injury-related variables such as safety belt use, vehicle deformation, vehicle speed, driver age, and vehicle weight are taken into account, the drinking driver is significantly more likely to suffer serious injury or death in an auto accident. The study concludes these statistics support laboratory work with animals that shows alcohol is associated with an increased severity of traumatic injury. "If it is clearly established in humans the mere presence of alcohol enhances the degree of any injury occurring, alcohol education must communicate the potential hazards of being intoxicated when exposed to any risk of injury, whether the intoxicated person is in control of the situation or not," the researchers say.

Journal of the American Medical Association, September 19, 1986, v.256:1461-1466.

Teen girls use drugs more than boys

Among 14 to 16 year olds, females abuse virtually all drugs, including alcohol and tobacco, more than males, a 1983 survey of Ontario youth shows. Data from the cross-sectional survey of more than 1,000 adolescents between ages 12 and 16 was analyzed by two researchers from the child epidemiology unit, psychiatry department, McMaster University, Hamilton, Ontario. Self-administered questionnaires were used to assess use of tobacco, alcohol, and a range of illicit drugs. Many of the findings of David Offord, MD, director of the unit, and research associate Michael Boyle confirm those of similar recent surveys, including the prevalence rates of almost all categories of substances increasing with age. One persistent trend is greater drug use among girls. Data for the 14- to 16-year-old group suggest more girls than boys use alcohol, marijuana, and other drugs. "The differences, while admittedly small and non-significant," say Dr Offord and Mr Boyle, "are by no means trivial and warrant further research." This finding, they add, could indicate the need to tailor preventive programs separately for pre-adolescent boys and girls.

Canadian Medical Association Journal, November 15, 1986, v.135:1113-1121.

Pat Rich

Exposure to risk helps kids resist alcohol, other drugs

By Terri Etherington

TORONTO — Simple-minded interventions and paternalistic regulations will only make the problems of drug abuse among youth worse, warns a Calgary consultant on human behavior.

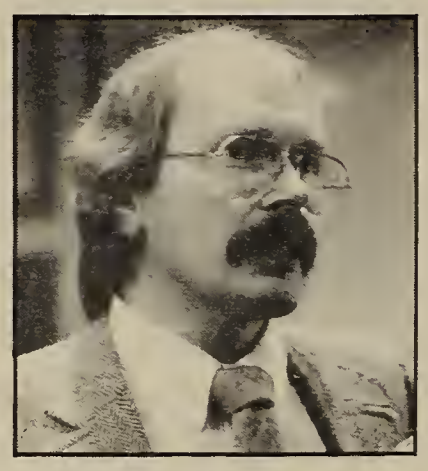
What's needed is a whole new approach to education and child rearing, emphasizing opportunities for young people to test and develop their skills in judgment and decision-making.

In fact, says Ken Lowe, president and founder of the Action Studies Institute, Calgary, what's needed is a return to the principles of developing character skills and of teaching children the values of courage, bravery, innovation, and community participation.

Mr Lowe: "The fundamental issue of pragmatic primary prevention for intoxicant problems is not the (drugs) themselves. Those sirens and temptations, in one form or another, will always be with us. The question is, how are we preparing our youth to manage the challenge of freedom? That is the issue."

And, says Mr Lowe, "right now, we are not doing such a wonderful job" (see People, page 1).

He told the Drug Education Coordinating Council's 4th annual conference here: "We have devastated the character skill capacity of our youth by loving them to death, by eliminating the opportunities for them to sail on rough seas, by eliminating the possibility of them being exposed to situations that do require foresight, judgment, and decision-making. We have adopted, as a culture, the



Lowe: rough seas

notion that all our human problems can be solved simply if we acquire more information."

The key to understanding the attraction of alcohol and other drugs is that it doesn't take any skill. If you can swallow, you can get there, says Mr Lowe, a contributing editor for the Alberta Alcohol and Drug Abuse Commission's teen magazine, *Zoot Capri*.

Underlying the problem is that children are no longer taught to function in teams. The school system, as we have created it, he said, is primarily set up to produce people who can function in factories and bureaucracies.

"In bureaucracies, the foremost character skills required are compliance and diligence; meaning that you accept a task as it is provided to you, you think up to the boundaries of that task, and you do not think beyond that. Because that is the way factories and bureaucracies operate."

Mr Lowe: "The major socialization function of schooling is to inure children to accept purposes created by other minds, follow rules and procedures derived by other minds, to arrive at products and conclusions known in advance, because, by and large, that is the major form of participation in our culture."

Those are the very things that make kids so widely susceptible to dependency, he said.

And, the drug explosion came just as the first generation raised in front of the television was hitting the streets. Their expectancy for high-level, passive stimulation was great.

This created problems in producing interesting, worthwhile experience in a culture where "we have sanitized the possibility of taking risks, where we have created a situation that loyalty and courage can only be words for the majority of children, because we do not provide them with any significant tests for loyalty and courage."

Mr Lowe said as a young person he spent much of his life shooting a B.B. gun in the back yard, setting off fireworks, building bonfires, climbing trees, or playing on the river ice in the spring.

"Do any of those kinds of things today, and you'll have 14 squad cars out there. 'What are you doing? Want to hurt yourself? Want to poke your eye out? Want to break your neck?'

"We have created a life where we imagine that keeping kids in this very efficient cage, safe, without risk," is good for them.

"If what we are interested in is helping kids understand how to solve problems, how to learn, how to exercise judgment, intelligence, creativity, imagination, we aren't doing a terrific job."

ARF community service award

RIDE coordinator is honored

TORONTO — Sergeant Donald Colbourne, the Metropolitan Toronto police officer in charge of the drinking/driving spot check program, has been named first recipient of a community achievement award from the Addiction Research Foundation (ARF) here.

The award was presented to Sgt Colbourne at the launch of the 1986 holiday spot check program RIDE (Reduce Impaired Driving Everywhere).

Sgt Colbourne worked closely with the ARF and the Etobicoke Safety Council in developing the program in 1979 and is now coordinator of the year-round RIDE program throughout Metro.

In the citation, ARF chairman John B. MacDonald, PhD, said Sgt Colbourne's outstanding contribution to the implementation, preservation, and furtherance of the prevention concept through RIDE "has helped to save many lives and to protect the quality of many more."

Joan Marshman, PhD, ARF president, told staff the new award is an "opportunity to recognize the valuable contributions made by exceptional individuals in communities across the province.

"In making this first award to Sgt Colbourne, the foundation has certainly set a very high standard."

Colbourne: lives saved

Turner resigns White House post

WASHINGTON — Carlton Turner, PhD, has resigned here after five and a half years as director of the White House office on drug abuse policy.

Dr Turner told The Journal he is leaving "because I'm tired.

"I think I have accomplished more than any other person who's held the job, that's not vanity talking, that's reality talking. I think we have raised the drug issue to a higher level than it has ever been raised before.

Turner

"I think the first lady (Mrs Nancy Reagan) has turned the world's consciousness upside down on this issue; the president (Ronald Reagan) has gone out with the national crusade mobilizing everyone

"We are now taking on drug use in the workplace.

"But, it's time for me to spend some time with my family."

Dr Turner said he has contemplated retiring several times in recent years, but "it just wasn't right at the time."

Although he is happy with the amount of money the United States Congress recently voted for the fight against drug abuse, Dr Turner said he is unhappy Congress failed to hold the user accountable.

The legislators took the view they spent a lot of money on hardware, he said — "let's screw holes in the sky and look for drug traffickers." And, they didn't go along with the president's approach to put the focus on the user and hold the user accountable.

"To me, unless you make the user pay a consequence, you are not going to solve drug abuse. As long as the user is there buying the drug with impunity, you are always going to have the planes flying."

HEALTH PROMOTION

Redefining health — the momentum is building

'So much disease, disability and despair is preventable'

OTTAWA — The new Ottawa Charter for Health Promotion (see page 1) was developed here after a week of intensive discussion on common concern for health, as it moves beyond care and cure. But, its roots reach back more than a decade.

The Journal *Editor* Anne MacLennan *reports on the evolving health promotion movement and interviews international expert R.A. (Ron) Draper of Canada.*

The charter, and the meetings here, grew out of another charter and meeting — the Declaration on Primary Health Care, drawn up in Alma Ata, in the USSR, in 1978 — as well as the World Health Organization's (WHO) health-for-all target, and debate about the need for intersectoral action for health.

Whether it finds and holds a place in history — becoming an important point in a movement that will only look inevitable in retrospect — depends essentially on two things: its continued reach into hearts and minds and its adaptation to particular societies and circumstances; and continued support from the growing number of individuals, associations, and governments committed to the ideals it reflects.

In principle, along with many other governments, this includes Canada's, which, through Health Minister Jake Epp, released at the Ottawa conference its own contribution to the debate: *Achieving Health For All — A Framework for Health Promotion.*

Catalytic in the development of the ideal has been the awareness that established medical care systems and interventions cannot solve health problems. For some, in developing countries, even the most basic health care is not available. For others, in the developed world, costs are soaring and returns diminishing.

Halfdan Mahler, MD, WHO's director-general, told the conference at the outset: "At its heart, this crisis is political: blatant inequalities in health status still exist in most countries despite high levels of medical care.

Medical care has not "reacted adequately to the changes in the illness panorama of the developed world, and it is moving with great speed into technological solutions that are of little help to those who are hungry, in chronic pain, or in fear of death.

"The tragedy of the health situation in the industrialized world is the knowledge that so much of the disease, the disability, the chronicity, the premature death, the mental despair is actually preventable.

"We do not need just a little bit more health education here and a little bit more prevention there. We need a new approach to public health action, and we need a strong public health alliance to move us forward."

Canada has been a pioneer in health promotion.

Dr Mahler: "No one can speak of new developments in public health in the second half of our century without mentioning the report: *A New Perspective on the Health of Canadians*, issued in 1974 (see Responsibility, page 1). It opened the door to a new discourse on health which had influence on the focus of public health thinking and action far beyond Canada itself."

Canada was also one of the first countries to establish within the government a group responsible for health promotion — the health promotion directorate.

Director-general since its inception has been Ron Draper, the key figure in Canada and one of the key figures in the field internationally, along with Ilona Kickbusch, PhD, chief of health education, WHO regional office, Europe.

Mr Draper was also, until recently, co-chairman of the federal/provincial sub-committee on alcohol and drug problems in Canada and is a member of **The Journal**'s editorial advisory board.

Following are excerpts from an interview with **The Journal** Editor *Anne MacLennan* in which he discusses both health promotion and the addictions field.

AM: This first international meeting on health promotion is the culmination of three or four years of organizational work and debate. What is it you are trying to achieve?
RD: Basically, we are trying to redefine health promotion, to change it from a narrowly defined, disease-prevention or risk-reduction phenomenon concerned with things like diet, and things like drugs and alcohol abuse, into a broad debate, into a socio-ecological approach to prevention.

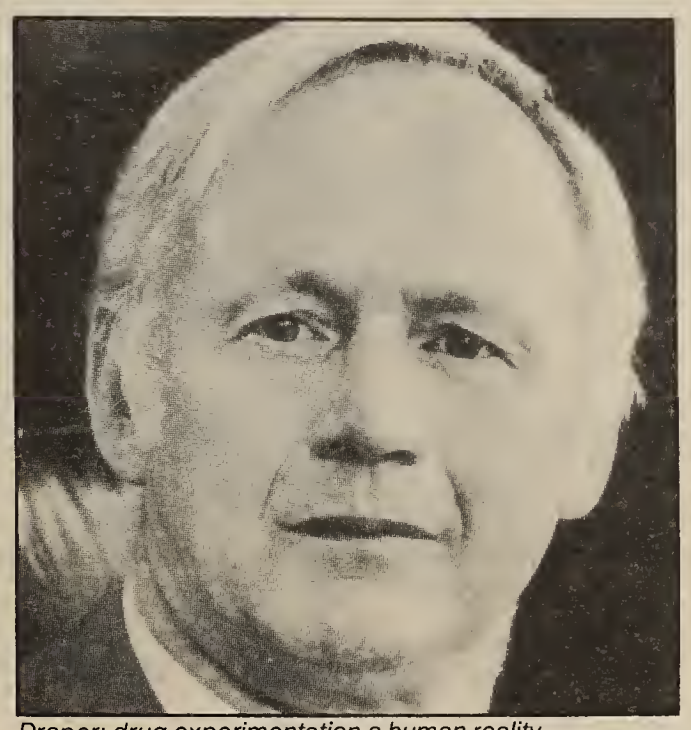
AM: Nationally and internationally?
RD: Nationally and internationally. We're banking on the assumption that if we can get enough international leadership forums, it will make it easier to do things nationally, domestically. The point in all of this is to build consensus and to build a network.

AM: Where will the charter go now? To governments?
RD: That's the idea. Delegates can take it back to whomever it is they work for and say we have a consensus. Anne Kern for example (deputy secretary for health in Australia) is anxious to take that kind of statement back to the Australian government in Canberra. The next move there is to have a conference like this in 1988.

So, what we are doing is building consensus, attracting attention, clarifying what these concepts mean in practice, extending the number of people who know each other and can ring each other up, extending the knowledge of practical advancement in the field. All of which is to try to generate social support and political will in general for the health promotion idea.

AM: This meeting — and charter — have followed on a meeting in Alma Ata in the USSR. Could you explain?
RD: That was in 1978, and that essentially grew from the World Health Assembly resolution on health for all, which came out in 1977. That was the most crucial conference of the WHO; 160 countries were there, governments were there, government representatives were there, and they came up with the Declaration of Alma Ata. They said this is what primary health care is and this is how you do it.

AM: You've moved beyond that?
RD: Yes, we're moving away from the cure and care idea. But, we're trying, in a small way, to create another Alma Ata here.



Draper: drug experimentation a human reality

AM: But evolving from there?
RD: That's right. The original idea in the 1977 resolution was a very radical idea. It was based on citizen participation and intersectoral coordination. It is my theory that the radical thrust of the original resolution got lost. What we are trying to do here is get that back.

AM: Some critics have argued that the WHO and health promotion have more to do with developing than developed countries, where standards are high and there is greater access to health care.
RD: The problem in developing countries is that they still don't have primary health care in place. I mean, Bangladesh has got what, one doctor for every 10,000 people . . . something like that. The fact that a country does not have basic health care is just not acceptable. So, they are still proceeding with the primary health care idea.

In fact, the reason we had this conference for industrialized countries was that, when we had the working group meeting four or five months ago in Copenhagen, we ran into a dichotomy: the industrialized countries were interested in the idea, and the developing countries were not. So we said, okay, we'll go ahead with the industrialized countries now, get that underway on some global basis, generating political will.Then, we'll get back to the developing countries.

'You have to take a whole different look at the issue of addictions, contributing some realistic context'

AM: Because, in fact, to go this next step to disease prevention you need primary care in place.

RD: That's right, there must be medicinal care available. One can argue, for example, that in a country like Bangladesh it would be better to invest in population control and nutrition and clean water, and just forget the care idea. But, that's not acceptable either.

AM: What is happening then in Europe, for example?

RD: What has happened in Europe is interesting, in terms of international consensus. As Asvall (J.E. Asvall, regional director for Europe, WHO) said in his address, the 32 member states of the WHO European region (representing some 800 million people) have agreed a major part of their health problems come now from affluent lifestyles.

Their discussions culminated in the *European Strategy for Health for All* and a firm statement, with 38 health-for-all targets, specifying how far the region should go in the next decade or so.

That has profoundly changed the focus of health planning. It wouldn't surprise me if, by the end of the decade, we have pretty explicit statements of health policy all over Europe which incorporate statements about health promotion. The report released the other day (by Mr Epp) is really the nearest thing you can get to a federal policy statement on health promotion in Canada.

AM: What would you like to see by the end of the decade in Canada?
RD: I would like to see a much more explicit statement of policy, with some goals attached to it that had really been ratified by the federal government after consultation with the stakeholders — provinces, health care professionals, community groups, that kind of thing.

AM: It's surprising Canada hasn't had a set of operating principles already.
RD: Yes, but I don't think Canadians work that way, do you? I mean where do you know of an official statement of health policy in Canada? We prefer to be much more *ad hoc*.

For some reason too, when all of this fee-for-service clinical care got going, we lost interest in public health in this country, and public health departments have been a low priority for probably two decades now.

AM: Is there some light now at the end . . . with respect to public health? Do you see any kind of renewed stirrings of interest and creativity?
RD: I do. What's missing, at the moment, is someone to do real networking, to get these people all together and to get them political recognition. We should now have a Canadian conference like this.

We've been very innovative in the past. Part of the issue is that there is no crisis in this country, you can look at it that way. Other than AIDS, there are no epidemics around that I know of . . . .

But, a lot, in terms of this country, depends upon what follows now. From provincial governments, from national organizations and associations, and a few academics and others.

AM: So, the future in a sense is lodged with them too.
RD: Yes, and in reactions to the report, *Achieving Health for All*.

AM: How does this all relate to the addictions field, particularly to the thrust to create a national drug strategy?
RD: The problem I have with the demand reduction (prevention) side is this: I think the specific drug information, drug education, drug-related community organization must be put in a context. You have to take a whole different look at the issue of addictions, contributing some realistic context. It is time to look at the issues as they are, to look at drug use for what it is.

On the one hand, it's an expression of experimentation, an expression of pleasure and the excitement around that. On the other, it is an expression of a pathology — human pathology. But that pathology is not specific to addictions, it is part of the human condition.

AM: But, even if you take a totally health promotion approach, is it not necessary to tell parents or kids what a drug does, or why people like it?
RD: Oh yes, sure. But, I think, by and large, we are pretty dishonest. I think we ought to tell people what we know about the stuff — if we can be honest. I think we ought to do more to explain drugs in a context. The percentage of the population that uses heroin, for example, is never more than 5% or 6%; it is a marginal problem. You ought to have a public discourse on that kind of knowledge.

When you've done that, you haven't done any prevention, in a real sense. All you've done is made the public a little more knowledgeable.

But, once you've got more knowledge, once you've got an open discourse with the public, then you can begin to think about what you do in a broader public health context about the fact that experimentation with drugs is a human reality; that it will go on in any non-oppressive, pluralistic society; that people will experiment; and, that using chemicals to produce temporary blurring of reality — and feelings that are different from reality — is a normal human condition that has always been with us and always will. Sometimes, this becomes pathological, and you need to look at that pathology in terms of social conditions and what you can do to alleviate that.

Once you've got a knowledgeable public, you can begin to work on those other issues.

An international conference on Health Promotion

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Editor... Letters to the Editor... Letters to the Editor...

Alcoholism/battering — a complicated issue

Some questions outstanding

Thank you for the interesting article, Violence and alcohol: a strained connection (November).

The linkage between alcohol abuse and domestic violence certainly is a complicated issue. I found the article informative and thought provoking. However, it left some questions unanswered for me.

I do not question that most batterers are not alcoholic. My own experience as an addictions counsellor for 15 years supports that.

But, many alcohol abusers are also spouse batterers; I would suspect a much higher proportion than in the population at large. Is there statistical data available on the percentage of alcohol abusers who are also wife batterers?

I certainly agree battering is an issue of power and control. An interesting adjunct to this is that alcoholism is also, on a personal level, very much an issue of power and control (or of powerlessness) over one's self and one's life.

It, therefore, is not surprising that many alcoholics also batter.

In recovering from alcoholism, the individual regains control over his/her own life. In the process, many (not all) also stop battering.

Having developed new, healthier skills for achieving power and control in their own lives, spousal power struggles become less intense.

These issues must be directly dealt with in recovery.

Marshall Hoke,
Alberta Alcohol and Drug Abuse Commission
Edson Area Supervisor
Edson, Alberta

Give help first, diagnose later

I have been a counsellor of people with alcohol problems for 38 years, and sometimes I feel we haven't learned a thing. A case in point is The Back Page (November), Violence and alcohol: a strained connection.

I will agree wholeheartedly with the author that alcoholism gets a bad rap. All sorts of behaviors related to the use of alcohol are attributed to alcoholics when, in fact, much of unacceptable behavior we see as counsellors is acted out by those who are not alcoholics, or at least those whom we have not yet been able to diagnose as 'alcoholics.'

(Ed note: Statistics are available in the book, Statistics on Alcohol and Drug Use in Canada and Other Countries *from the Addiction Research Foundation, Toronto and* Alcohol in Canada, A National Perspective *from Health and Welfare Canada, Ottawa.)*

Any counsellor who is going to have any degree of success in helping people faced with problems related to alcohol is going to have to forget for a while trying to diagnose 'alcoholism' before trying to help a person.

If alcohol is causing a problem, forget about trying to diagnose the problem and get on with dealing with alcohol.

In a long and often not-so-successful career of trying to help those with problems, I have found it extremely useful to get the alcohol out of the way first. Once that is accomplished, it is much easier to see what we are dealing with and to see that the proper routes are followed.

As long as alcohol is involved, both the client and the counsellor have trouble seeing things clearly.

One could sum it up very simply: many people have problems relating to alcohol who are not or have not been diagnosed as alcohlics. Some of them are even counsellors.

Robert C. Hickle
Waverly, Iowa

Columns draw criticism, praise

One reader dismayed

As an addictionologist, I was extremely dismayed to see Richard Gilbert promote the myth that beer may be better for an individual than other alcoholic beverages containing equal amounts of alcohol (August).

While citing the poorly controlled "research" of Richman and Warren, which was sponsored by the Brewers' Association of Canada and the United States Brewers' Association, Dr Gilbert neglected to cite other studies that support the concept a drink is a drink is a drink. He totally ignored the US Surgeon-General's report (1984) that stated: "Two or more beers per day triple the chances of developing rectal cancer."

Indeed, the Surgeon-General's report seems to indicate, contrary to Richman, Warren, and Gilbert, that, all other things being equal, a drinker would be better off drinking any other alcoholic beverage.

Dr Gilbert's articles in **The Journal** are generally quite interesting and usually informative. This one, however, is seriously misleading to your readers and demonstrates well the problems one is likely to encounter when basing an entire premise on a single, and in this case most likely biased, source of information.

Louis A. Pagliaro, PhD
Coordinator, Master of Pharmacy Program
University of Alberta
Edmonton, Alberta

. . . another moved

Many thanks for a very impressive publication. **The Journal** is always packed with 'good stuff' ranging from the arcane to the droll.

In the November edition, the column, *Inside Out*, seemed particularly poignant. Its ring of truth recalls for me another line attributed to Sir Winston Churchill: "There, but for the grace of God, go I."

Having worked almost 27 years with probationers and parolees, I have come to know thousands of alcohol and other drug abusers. *Inside Out* portrays them both vividly and with sensitivity.

The writer has a gut feeling for the sometimes heart-wrenching struggles of ex-abusers trying to survive and rebuild their lives. Such authentic stories are seldom seen in the commercial press, much less on television

Perhaps **The Journal** will receive credit someday for helping such writers launch careers in aid of sobriety. A small step, some critics will say; perhaps so, but those small steps are all part of the human struggle for survival.

J.F. (Fred) Brailey
Don Mills, Ontario

Young drivers and alcohol use — beyond the holiday blitz

AMSTERDAM — Teenagers who drive — automobiles, motorcycles, or mopeds — and teen passengers are consistently over-represented among road accident injuries and deaths.

And, while experience in the United States in the past five years has shown raising the legal drinking age can reduce the number of alcohol-related crashes, drinking itself is only a manifestation of the life most teens live.

There is no simplistic answer; alcohol does not equal crashes. Drinking while driving is only one aspect of many kinds of illicit behavior in which many teenagers engage.

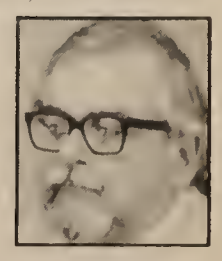
At a recent international symposium here on Young Drivers' Alcohol and Drug Impairment, Canadian researchers in particular presented detailed pictures of current teenage behavior and lifestyles. And, wide-ranging contributions from speakers from other countries — New Zealand, Sweden, Australia, Great Britain, France, the Netherlands, Switzerland, West Germany, Denmark, Finland, and the US — illustrate that the problem is not one confined to North America.

The conference was sponsored by the International Drivers Behavior Research Association (IDBRA), a non-profit, non-governmental public service organization headquartered in Paris. The IDBRA has held a number of international seminars, symposiums, and meetings covering the field of driving and road safety.

The association knows the problem will not go away: Timothy Benjamin, IDBRA secretary, pointed out 80% of the population in the Third World is in the 18-to-24-year age group.

At the end of the symposium, participants agreed to these conclusions:

- Motor vehicle accidents account for more than one-half of all male deaths in the 15-to-19-year age group in many countries. They are also responsible for a substantial and increasing proportion of the pool of permanent disability. In most countries, the per capita consumption of alcohol is increasing as is the number of young people driving motor vehicles. Convictions for driving under the influence of alcohol have increased, as has the abuse of drugs other than alcohol by young people.
- Alcohol is the most important cause of motor vehicle accidents in young people, and alcohol intoxication complicates the diagnosis and treatment of the injuries they receive. It also reduces their chances of survival or of recovering without permanent disability.
- Surveys from several countries show a solution to the abuse of alcohol and other drugs by young people in traffic will not be found by studying the problem in isolation.
- Important relationships have been shown between lifestyle, social environment, and attitudes of young people who drive while impaired by alcohol, as compared with those who do not. Much information has become available about adverse factors which influence lifestyle and attitudes, and this has enabled corrective measures to be proposed.
- An increase in the risk of accident involvement occurs in a substantial proportion of young drivers at lower concentrations of alcohol than is the case with older and more experienced drivers. Legislation enforcing a lower statutory limit for young or novice drivers has proved effective in reducing accidents in some countries.
- The introduction of discretionary (sometimes called random) breath tests has also proved effective in reducing road accidents in some countries, when it is combined with a concentrated and integrated program of public education.
- An effective approach to the problem of the abuse of alcohol and other drugs by young people in traffic will not be achieved until traditional barriers between departments and agencies (both governmental and non-governmental) concerned with transport, health and welfare, education, and law enforcement have been broken down so that comprehensive and integrated countermeasures can be introduced at national and local levels.



McConnell

Washington Contributing Editor Harvey McConnell reports on the conference, pages D2 to D4.

(from page D1)
Most adults in all societies have expended great energies saving the younger generation," observed Morris Chafetz, MD, former director of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) and now head of Health Education Foundation Inc in Washington, DC.

He said the reasons young people injure themselves and die in traffic accidents can be explained through "a host of complex inter-relationships. Driving is a complex, integrated activity, and adolescence is an ill-defined, physical and emotional period of transitions.

"The taking of alcohol requires an intertwining of psychological and environmental responses varying from time to time and place to place, even for the same individual."

Dr Chafetz pointed out there is a need for a new social norm: "There is an appreciable difference between getting drunk and taking alcohol. There is a big difference between education and information."

One mistake being made is to think anti-smoking models can be used equally as well with alcohol: "There are no health benefits to the moderate use of smoking, but there are certainly well-tested benefits to the moderate use of alcohol."

Many young United Kingdom drivers have a misconception of how much they can drink and still legally drive

Commenting on the recent raising of the drinking age to 21 years in most US states, Dr Chafetz said: "We have given them permission to engage in all adult behavior except to drink. And, at the same time, there are 22 million or so users of cocaine and nearly as many users of marijuana, and we wonder why the young people pay no attention to what we say."

He believes enlightened self-interest is a key factor for change. With colleagues, he has developed a server (bartender) trainer program, and research at a major Virginia university has shown it can be effective.

Ian Johnston, of the Victoria Road Traffic Authority, Australia, said about three decades have passed since it became freely accepted that alcohol plays a major role in road crashes. Yet, progress, with emphasis on the justice system, must be considered disappointing.

The emphasis has swung from drunk driving to drinking and driving, from detection to general deterrence, and penalties have been increased appreciably.

What makes drunk driving so difficult to deal with — in the past, present, and future — "is the fact that drinking behavior and driving behavior are prevalent, legal, and socially acceptable behaviors, and both are considered acceptable to social interaction."

Barry Sweedler, of the bureau of safety programs, US National Transport Safety Board, Washington, DC, remarked that people from other countries may have been perplexed in recent years at the US furor about raising the drinking age to 21 years.

The fact is, though, that all industrialized nations suffer from the problem of youthful drinking and driving. And, it has been shown that the number of alcohol-related highway deaths among 18- to 20-year-old drivers dropped when the drinking age was raised.

"We do not think raising the age to 21 years will solve the problem: no one measure will. But, passing a 21-year drinking age may be one of the most effective ways of cutting the highway death toll."

H. A. de Boer, secretary-general of the Netherlands Ministry of Welfare, Health and Cultural Affairs, pointed out young road-users who make the highways unsafe by drinking and driving are in a special category.

"It is certainly not my intention to cast the blame on young people and thereby play down the share of older drivers in road accidents. Nor do I wish to over-emphasize the differences between men and women. Nevertheless, the fact of the matter is that the majority of serious road accidents are caused by young men under the age of 25 (years)."

Mr de Boer said there are two trends in the western world: First, "young people now tend to drink more frequently and to consume greater quantities than was previously the case. In the Netherlands, for example, many 15 and 16 year olds drink as much as adults, although I would be reluctant to call such behavior 'adult.' This drinking takes place mainly at the weekends when young people go out.

"Second, increased prosperity has meant many more young people drive motor vehicles and have their own moped, motorbike, or car. Whereas adults keep their cars primarily for family use or to drive to and from work, young people generally go out in cars or on mopeds in the course of their leisure pursuits, mainly at the weekends, and therefore also after they have been drinking."

Another worrying factor in recent years has been a steady increase in the percentage of women driving with high blood-alcohol concentrations (BACs).

Mr de Boer noted this past autumn the Netherlands government approved a policy drawn up by his ministry to restrict the availability of alcohol in schools, youth centres, and sports-club bars and to prohibit the sale of alcohol at gas stations.

An alcohol information program is aimed a young people. "Society has become so tolerant of drinking that a fundamental reappraisal of alcohol and drinking habits is urgently needed," he added.

One should not be blind to reality: many young people have never suffered physical or emotional damage from their drinking. Many think in the short-term and not of tomorrow; they are unresponsive to campaigns about the risks of alcohol because in their minds alcohol has only pleasant associations.

It is natural for young people to overstep the bounds; they should be given a certain amount of freedom to do so. On the other hand, how can this be reconciled with well-intentioned warnings about the risks of immoderate behavior, be it drinking, smoking, or speeding?

Mr de Boer said the young are no different than their elders: all of them think they know everything there is to know about alcohol. They are as susceptible to the myths that beer is less harmful than wine or spirits, or that a drink or two improves driving ability.

Mr de Boer: "These notions stem from a desire to portray alcohol as being relatively harmless, and the fact that people have deep-seated motives for minimizing the risks indicates it will not be easy to dispel these myths and convey a more realistic concept of what drinking entails."

A random US survey shows the number of teens driving after drinking has declined since 1979

John Havard, MD, secretary of the British Medical Association and chairman of the symposium, noted the obvious paradox: while strides against communicable diseases have been astounding this century, one could view deaths on the road in a similar light to see, paradoxically, that in some countries, crashes account for nearly 50% of the deaths of young men aged 15 to 19 years.

"Yet, this attitude contrasts starkly with public reaction to deaths from life-threatening, communicable diseases such as AIDS," he added.

Another factor is that for many automobile accident victims medical science has progressed too far: their lives can be saved, albeit their future existence will be curtailed.

Dr Havard: "It is not generally appreciated that young people have a much better chance of surviving serious trauma than older people. The consequence is that the young, in increasing proportion, are responsible for a pool of incapacity and disability in the community."

Head injuries, spinal cord compressions, and major skeletal disintegrations they suffer mean "many survivors are confined to a cabbage-like existence." And, the cost to the health care system is enormous.

More similarities than differences are to be found in the most recent studies in a number of countries of drinking driving patterns of young people.

J. T. Everest, of the Transport and Road Research Laboratory, Crawthorne, the United Kingdom, said in 1984, some 260,000 automobile and 64,000 motorcycle drivers were involved in injury-producing accidents. Figures show 3.6% of them were either positive for alcohol on a breath or blood screen, or were presumed to have alcohol in their blood because they refused to provide a specimen.

The highest incidence of fatalities having BACs above the legal UK limit (0.08%) was for drivers in their early 20s (41%), with the level falling to 36% among those in their late 20s and down to 14% among those older than 40 years. Conversely, about 60% of those older than 35 years had a 0.15% BAC compared with 33% of the 20 year olds.

Among teenage drivers, the figures were significant: only 20% were above the legal limit. On average, among all drivers, 35% reported they had been drinking some amount of alcohol before their accident.

At present, Mr Everest said, the laboratory is carrying out a study with the police in Nottinghamshire, to establish drunk-driving patterns and characteristics of drivers and riders in relation to their levels of blood alcohol at the time of an accident. Drivers with high BACs are to be interviewed at home and compared with a matched control group.

Mr Everest: "An understanding of the characteristics and drinking habits of people who drink and drive is fundamental to the development of effective countermeasures. Relatively little of this research material is currently available to assess the situation in Great Britain."

Some studies are now underway to assess social background, use of vehicles, age, and drinking habits.

G. Kroj of the Federal Highway Research Institute in West Germany, said their studies between 1980 and 1984 found the *number* of fatal, alcohol-related accidents declined by 25%, and by 21% of all known accidents in which alcohol was involved. Nevertheless, the *percentage* of fatal, alcohol-related accidents remains more or less the same.

About 40% of drunk drivers involved in accidents in 1983 were aged between 18 and 20 years. Yet, the institute studies show young drivers drink alcohol less frequently than others, and, as in the UK, the BACs of intoxicated young drivers involved in accidents are lower than those of older drivers.

Young men with driving licences for nine months or less had the greatest reluctance to drive after drinking.

Young driv — beyo

Attitudes, however, toward drinking and driving are the same for young and older drivers. Those who do drink and drive worry less about breaking the law, seem willing to take more risks, and rate lower than other drivers the possible risks of drinking and driving.

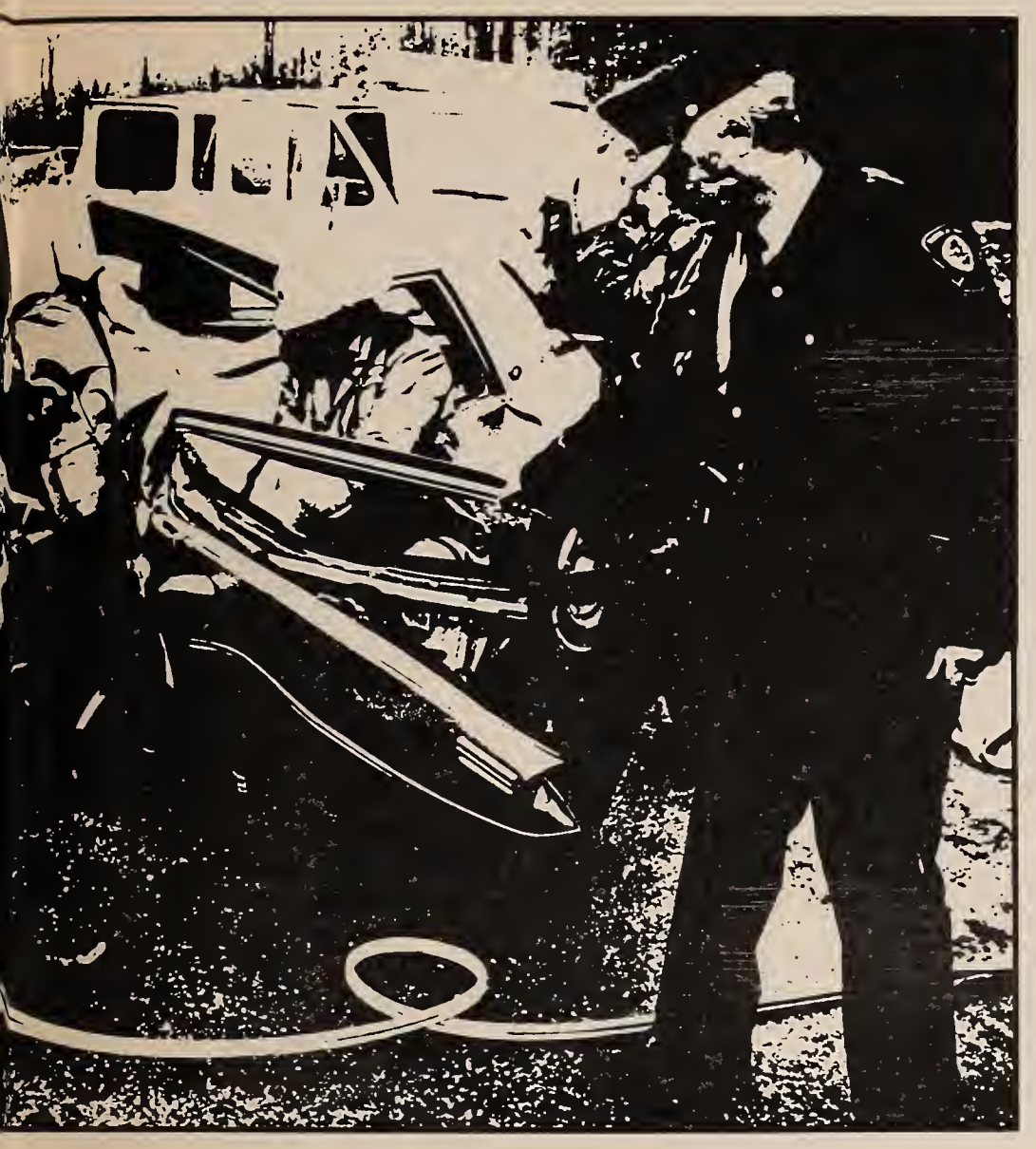
In the Netherlands, many 15 and 16 year olds drink as much as adults

For these reasons, Mr Kroj declared: "As attitudes are the same as in the general population, any measures directed at special groups will be severely limited in what they can achieve."

Drinking practices particular to Finland are exhibited even by young drivers, said Antii Penttila and Jarmo Pikkarainen of the Department of Forensic Medicine at the University of Helsinki and the National Public Health Institute. Drinking to get drunk is the dominant feature.

The percentage of young people arrested for drunk driving has steadily increased, and various countermeasures so far have been fruitless. At present, driving while intoxicated is most common among 18 and 19 year olds.

The Finnish studies show young drivers know what they are doing and fully intend to drive after drinking. Riding around with friends at late hours on the weekend is common; most passengers have been



ivers and alcohol use ond the holiday blitz

drinking as well, and only a small minority of them try to dissuade the driver from taking the wheel.

Half of the young drivers were found not to have valid licences, despite a high risk of detection by police and their overriding worry that being caught postpones the day they would get a valid licence.

A study of drunk drivers less than 20 years old found they started drinking as young as 13 years, drank at least 10 bottles of beer on two weekends a month, and only a few thought they had any problems with alcohol. Further investigation showed, however, that the rate of problem drinking in this group is quite low.

Motorcycles are a major source of accidents and deaths among young people in New Zealand, where about 70% of fatal accidents happen in rural areas, says John Bailey, of the chemistry division of the New Zealand Department of Scientific and Industrial Research.

Motorcycles account for only 7% of the licensed vehicles in the country, but motorcycle riders are involved in about half of all fatal injuries on the road among young people, and about half of all injuries in drivers of all ages.

Mr Bailey: "Cannabis as well as alcohol may well be a significant problem for motorcyclists among the 20 to 24 year age group." Radioimmunoassay of samples taken from accident victims admitted to one major hospital found 18% of the motorcyclists had been drinking and 16% had been using cannabis.

"It appears possible cannabis users are possibly heavy and/or regular drinkers as well," he added.

Prescription drug use is only a minor problem among all drivers, and alcohol remains the major intoxicant for those injured in road accidents. Cannabis is a problem among certain groups.

Richard Jessor, Institute of Behavioral Science, University of Colorado, Boulder, has taken a wide-ranging psychological approach to dangerous driving and adolescent problem behavior.

He said risky driving — speeding, following too closely, driving after drinking or drug use — is part of a larger syndrome of adolescent problem behavior.

Among the young people he and colleagues have studied, there is lower parental support and control, lower peer control, lower compatibility between the parents and friends, a greater influence by friends than parents, less parental disapproval of problem behavior, and, most particularly, greater approval from friends as the model for problem behavior.

"Even problem drinking can serve a variety of functions central to normal adolescent development. Many of these same functions can be served by other problem behavior as well, including risky driving," Dr Jessor added.

His data suggest problem behavior be viewed as part of the way of life of many young people, instead of as a separate behavior. Those with problem behavior in adolescence differ in their frequency of drunkenness, frequency of marijuana use, delinquent behavior, and sexual experience (more).

Herbert Simpson, PhD; Douglas Beirness, PhD; Daniel Mayhew; and Alan Donelson, PhD, of the Traffic Injury Research Foundation of Canada, Ottawa; and John J. Lawson and Jean Wilson, PhD, of Transport Canada, made several contributions on alcohol and other drug impairment of young drivers, lifestyle factors, and why young drivers are at greater risk of collision.

They point out that in the past two decades, road accidents have been the biggest cause of death and injury among young people in industrialized countries, and, while young drivers are over-represented in road crashes, even when the amount of exposure to risk is controlled, it still has not been clearly established why this is so.

A causal relationship remains obscure: alcohol is neither a necessary, nor a sufficient condition for collision to happen. In fact, most collisions involve young drivers who have not been drinking.

In addition, a majority of young people who do drink and drive do *not* have accidents.

Dr Simpson: "In retrospect, it now appears that preoccupation with alcohol as a risk factor, particularly in the crash experiences of young drivers, has proved a hinderance in identifying other factors that contribute to crashes involving young drivers — including those involving the use of alcohol beverages."

It is necessary to look beyond the amount of alcohol they drink and to consider other factors, such as those enumerated by Dr Jessor.

As part of a study funded by the Alcoholic Beverage Medical Research Foundation at Johns Hopkins University, Baltimore, Maryland, Dr Simpson and colleagues questioned 801 Ottawa-area high school students from both rural and urban areas. The study was about equally split between boys and girls aged 13 to 19 years.

They found 296 of the students said they had a driving licence and slightly more than 20% said they had been involved in an accident while behind the wheel.

Those who had had accidents could be distinguished from those who did not on a number of measures: they had higher levels of sensation-seeking, greater tolerance of deviance, more liberal social attitudes toward alcohol, and were less likely to agree with the idea, 'Everyone has a responsibility to avoid things that can cause sickness or injury.'

The largest group of factors distinguishing the drivers involved in accidents could be considered problem behavior: greater incidence of smoking and use of other drugs, lower incidence of seat belt use, drinking more, and more often, and a greater number of citations for moving traffic violations.

Dr Beirness said the factors "appear to represent a structured set of personality attributes, behaviors, and opinions indicative of a lifestyle oriented toward more unconventional expressions of self, less concern for health and safety, and greater sense of individuality and invulnerability.

"Although alcohol use is prevalent among accident-involved drivers, it represents but one aspect of lifestyle associated with greater risk of crash involvement, regardless of whether alcohol was actually a factor in the crash or not."

An almost similar set of characteristics and behaviors was found among young people involved in accidents as passengers, pedestrians, or cyclists.

These clusters of factors appear to have a more pervasive influence on young people, so they are at great risk of being in situations likely to result in a traffic accident, whether as drivers or passengers. In addition, they are at higher risk of other types of accidents.

Dr Beirness said their studies represent an attempt to go beyond the fixation by some that alcohol is *the* variable in crashes among the young, to explore other factors that might contribute.

Mr Mayhew said the available studies do not support the view that young people are more affected by alcohol than older people. The evidence appears the reverse: impairment induced by alcohol on various tasks increases significantly with the age of the person tested.

The best available evidence appears to show that, contrary to the general view, young drivers relate differently in their tolerance of alcohol. Factors other than pharmacological may play as important a role. Peer pressure may make teens disregard any idea of reasonable driving behavior when driving after drinking.

The extent to which tolerance and inexperience in driving contribute to increased risk in young drinking drivers is not well established.

Mr Mayhew noted one of the most persistent problems in studies examining age difference in the effects of alcohol is the definition of what constitutes 'young' drinkers.

As far as they know, there has been no such study on drivers with the highest relative risk of crash involvement at low to moderate BAC: those aged 16 to 18 years.

"Legal and ethical constraints have prevented researchers from administering alcohol to people who have not yet reached the minimum drinking age.

"Hence," he added, "there appears to be no direct experimental evidence concerning the effects of alcohol on people under 18 years of age. And, the limited state of present knowledge precludes definitive answers to questions surrounding relationships among age, alcohol, driving experience, and relative risk of crash involvement."

Mr Mayhew offered possible explanations on the higher relative risk to young drinking drivers.

One possibility is that "the disinhibiting effects of alcohol are translated into a greater willingness to accept risk among young drivers.

"Secondly, the higher crash risk of young drivers may be due to personal and social characteristics of a subset of this group: those who engage in risky driving behavior and who also happen to consume alcohol."

There is also Dr Jessor's suggestion of a general lifestyle that includes risk taking and problem behavior.

Mr Mayhew said a new factor may be that outlined by Markuu Linnoila, MD, of the NIAAA (**The Journal**, August) that young people have been found to be more chronically sleep-deprived than older people, and they thus show impairment after very small doses of alcohol.

James Farrow, MD, assistant professor of medicine and pediatrics at the University of Washington, Seattle, had 153 adolescents — including those with driving-while-impaired (DWI) offences, matched control juvenile offenders without DWI convictions, and high school drivers — analyze vignettes to assess attitudes and skills in making decisions about drinking and driving.

Dr Farrow said the DWI offenders, when compared with the control groups, came from homes with less parental income. There was also a greater chance their parents were divorced or separated, and they had lower grades in school.

In addition, the DWI offenders drank more often prior to driving; associated alcohol with many social events, including dating; became angry when questioned about their driving ability; and, drove fast to relieve stress. They were also much more likely *not* to seek help from a parent, or another important adult, in dangerous drinking and driving situations because they thought they would face undue criticism.

Motorcycle riders account for half of all fatal accidents among the young in New Zealand

Marked differences in attitudes and patterns toward drinking and driving are found in Australia between rural and urban populations, reported Mary Sheehan, of the Department of Social and Preventive Medicine at the University of Queensland, Brisbane.

Students from isolated rural areas were significantly more likely to expect their fathers and members of their immediate social groups to drink and drive. They also said the chances were high their favorite teacher would drink and drive.

The rural students "were significantly more likely to expect to have a good time if

(**continued** on page **D4**)

Young drivers and alcohol use — beyond the holiday blitz

(from page D3)

they drove after drinking. They also expected to get more fun out of the evening, and they were more likely to take part in more frequent drinking."

Ms Sheehan said there are different attitudes toward driving as well: 72% of the students questioned had driven their parents' cars in the previous month even though they were still too young to get a licence. Rural communities accept a different attitude toward such behavior.

A detailed study of 150 young drivers involved in accidents in which someone was injured has been carried out to help develop a countermeasure program from the Traffic Safety Planning and Research Department of the Insurance Corporation of British Columbia.

Peter Rothe of the corporation said the year-long study also included a survey of 1,500 16- to 19-year-old high school students and 20, five-member group interviews concerning driving.

Among drivers in injury-causing accidents, Mr Rothe said, slightly more than 50% included one or more passengers. About one-third of the drivers were taking part in animated conversation just before the crash; a third of the drivers thought their own interactions contributed to the crashes.

Most of the accidents happened on weekdays; it was found young people would hang around, decide to pile into a car, go for a ride, and look for a party. "The car was typically overloaded, and beer was often present."

Among the 1,500 other students, Mr Rothe said, they found 65% believed that driving with friends is safe.

As for partying, the researchers found those in grade 10 liked to take part most of all because it represented a new stage in life and, in a party scene, they were accepted by older students.

There is, in Australia, a marked difference in attitude to drinking and driving between rural and urban teens

Mr Rothe: "And, we found parents play a major role in why kids drink and drive even if they do so unintentionally. When parents want kids to be home at 1 am, the kids try to make it."

The paradox is young people doing the wrong thing for the right reasons. Instead of staying put if they've had too much to drink, they run the risk to get home on time so that parents won't be suspicious.

"When it came to the risk of driving home, compared to the certainty of punishment, they would take the risk," Mr Rothe said.

Any prevention program has to take into account the everyday life of young people, he added.

Since 1979, Ralph Hingson, PhD, and colleagues at Boston University School of Public Health have observed the changes in youthful behavior as Massachusetts tightened up its drinking and driving laws. Each year they do a random telephone survey of 1,000 teenagers.

They have found those teenagers who report driving after drinking in the past month has declined to 26% in 1985 from 51% in 1979, and those who report driving after marijuana use declined to 13% from 29% in the same period.

The number of fatal crashes involving teenage drivers dropped to 92 in 1985 from 181 in 1979.

As well, Dr Hingson added, the researchers found those who drive after heavy drinking: "tend to drive older cars, are less likely to wear seat belts, are more likely to drive after psychoactive drug or marijuana use, and are more likely to speed, run red lights, receive tickets for moving violations, be in crashes, and to be in crashes involving injury."

Dr Hingson said the figures can also be misleading; there are a number of variables which must be considered. For example, account should be taken of the miles driven, or the state of the economy, at the time a survey or study is made.

He and colleagues have found a factor limiting research is that much of it relies on self-reporting.

Over time, new laws tend to decay in their impact, and, in the final analysis the enforcement actions taken by police have a major impact on whether young drinking drivers are detected and or charged.

The Boston researchers have also used their random survey technique to study the effects in Maine of a 1983 law which suspends for a year the driving licence of anyone less than age 20 years caught with a measurable — defined as one drink, or 0.02% — BAC.

Among Maine's approximately 90,000 teenagers, some 1,500 had their licences suspended the first year, and around 1,200 in each of the following two years. The teenagers said, on the telephone, that their driving after drinking declined to 15% in 1985 from 31% in 1983.

A confounding factor was that only about 50% knew their licences could be suspended and only about 30% realized it could be suspended for a year. An additional problem is that the law is difficult to enforce because of the complexity of trying to decide if a teenager has had a drink.

Many young drivers have a misconception of how much they can drink and still be within the legal limit, a study by Andres Guppy and colleagues at the Applied Psychology Unit at Cranfield Institute of Technology, UK, showed.

A survey of 261 male drivers less than 25 years old found those who drank excessively thought they could consume significant amounts of alcohol without it affecting their driving. They also considered their drinking was within the legal limit; the perception of how much they could legally drink was much higher than among matched drivers who did not drink and drive.

If one accepts, as evidence seems to indicate, that predispositions in performance are more easily rectified than predispositions in attitude or behavior, then, suggests Ivan Brown of the Medical Research Council, Cambridge, UK, bring in compulsory driver training.

"Young drivers acquire vehicle control skills much more quickly than roadcraft skills," he said. Often, young drivers are exposed to traffic manoeuvers with which they are not sufficiently experienced to cope. Driver training should aim at reducing the discrepancy between perceived and actual levels of skill.

Similar views were expressed by Carol Boughton, Federal Office of Road Safety, Department of Transport, Australia. Young drivers need three general skills before they become safe drivers: manipulative, perceptual, and decision-making.

Under such a plan, novice drivers would be introduced to the road in gradual stages. This would increase the time before they acquired a full licence. But by then, they would be exposed to the difficulties of driving in situations with a higher-than-normal risk of accidents.

Half of young drivers studied in Finland were found not to have valid licences

John Moulden, alcohol program coordinator, US National Transport Safety Board, Washington, DC, advocates peer education as the most powerful tool in trying to persuade teenagers of the dangers of drinking and driving.

He said: "The advocacy of comprehensive alcohol and drug prevention programs would convey the implicit assumption that such prevention programs are demonstrably effective.

"Yet historically, drug abuse prevention programs have not been dramatically successful."

Experience has shown specially trained senior high school students should be sent to elementary schools "because in elementary schools when someone of that stature comes in, it is like God has entered the classroom," he said.

There is also a need for continual programs from the start of school to graduation from high school as all the evidence is that the effects of one time only programs are ephemeral.

In the UK, for a number of years, annual publicity campaigns trying to dissuade young drivers from drinking and driving have been produced by the Transport and Road Research Laboratory. The messages which appear most successful are those which emphasize the possibility of losing a driving licence and the fear of injury to a close friend or relative.

Barbara Sabey, director of the road safety division at the laboratory, said future publicity campaigns should be conducted in summer as well as winter, improve the driver's knowledge about the risk of getting behind the wheel after drinking small amounts of alcohol, point out beer is potent, increase the perceived likelihood at the local level of being caught, and continue to create an unsympathetic climate of opinion about drivers who drink and drive.

In Canada, researchers point out the causal relationship between alcohol and young drivers remains obscure

In a just-started program in West Germany, all new drivers will have to stay on probation for two years before they obtain a permanent driving licence.

Those young drivers who are caught drinking and driving will have to take part in a nine-hour program, for which they will pay, aimed at increasing their knowledge about drinking and driving.

"The final aim of this program is *not* total abstinence by the young drivers," explained Markus Jensch, of the Association for Education, Perfection, and Driver Improvement, Cologne. "The aim is that they manage to control their drinking habits; the motto is never more than 0.03% when driving."

He added that "the object of the course is not to avoid alcoholic beverages out of fear, but to control the problem and enable participants to handle and control with confidence their use of alcohol."

Mr Jensch: "The program is not set up to solve the problems of heavy drinkers."

Patricia Waller and husband Marcus Waller, both of the Department of Psychology at the University of North Carolina, have been long-time researchers in the field.

Ms Waller noted there are two different approaches that can be taken toward young drinking drivers.

The first, and most popular at the moment, views drunk driving as a matter of personal responsibility and has increased enforcement and sanctions, "although we do know, if penalties are seen as too severe, you can run into some backlash."

While the consequences of drinking and driving may be severe and may satisfy public demand for something to be done, this may divert attention from more effective measures.

Countermeasures could include increasing the drinking age, curfew laws, reducing availability of alcohol, changing taxes on alcohol, modifying the way the media portrays alcohol, and improving highway and automobile design.

Ms Waller: "Drunken driving is a predictable and inevitable effect of the social climate in which young people are reared, and until we recognize and deal with some of the consequences of drinking problems of youth, drunk driving will continue to be a major cause of morbidity and mortality of this age group."

Proceedings of the IDBRA symposium will be published early in 1987 and will be available through the Royal Society of Medicine in London. Write **The Journal** for further information.

British psychiatrists cite damage to nation's health

Public awareness key to curbing alcohol harm

By Alan Massam

LONDON — Alcohol far outstrips heroin and cocaine in the harm it causes to the nation, and doctors believe Britons should be drinking much less of it.

That is the central theme of a major report issued by the Royal College of Psychiatrists here.

It says that in the last 25 years alcohol consumption in Britain has risen by more than 50%, "with devastating consequences for the health and well-being of the nation."

The report continues: "Almost half a million people in the United Kingdom are dependent on alcohol, and 15% of men and 1% of women admit to drinking at a level known to be harmful.

"But, of far greater concern is the fact these represent the tip of the iceberg. Many more people have an alcohol problem they refuse to acknowledge or may even be unaware of."

The report records that on average, Britons drink the equivalent of 439 pints of beer or 31 bottles of spirits per capita annually, at a cost in harm of more than £1,600 million (Cdn $3,124 million).

Alcohol causes "vastly more deaths, suffering, and harm than heroin and cocaine, yet its familiarity means it provokes far less public concern.

"During 1983, 77 deaths in Britain were attributed to the inhalation of glue and solvents; 82 deaths to opiates and other illicit drugs, and about 4,000 deaths to alcohol," the report says. There were also 50,000 convictions for drunk driving and 5,000 first admissions to psychiatric hospitals for alcohol dependence and alcoholic psychosis.

As a result, the College wants to see more public awareness of the harm alcohol causes. It recommends a "safe" drinking level of 1½ pints of beer per day (or the equivalent) for men and one pint of beer per day for women, roughly half the rate recommended in its report seven years ago.

The College warns that above these levels the risk of harm increases. The risk becomes "substantial" if a man regularly drinks more than 3½ pints or a woman more than 2½ pints per day (recognizing that a pint of beer is equivalent to one double whisky or two glasses of wine).

As far as the nation's health is concerned, the College has no doubt about the impact of alcohol.

It says deaths from alcohol-related liver disease have doubled between 1970 and today, and cancer of the gullet and pancreatitis (both potentially-fatal, alcohol-related diseases) have also increased.

"Drinking is implicated in 19% of deaths by drowning, 39% of deaths from fires, and 43% of fatal falls. Sickness related to drinking contributes enormously to lost time and efficiency at work.

"Alcohol abuse has a devastating effect on family life," the report continues.

"Around 50% of battered wives are victims of their husbands' drunkenness, and excessive drinking is often associated with depression. Forty percent of male and 16% of female suicide attempts occur among excessive drinkers, and 33% of women attempting suicide report their husbands' drinking as the cause of desperation."

The College concludes national consumption of alcohol should be prevented from rising any further and, in the longer term, it should be reduced by one third. This will require, it says, a coordinated strategy from the government.

The report also suggests the government should monitor the sale and content of liquor advertising and curtail it if it is seen to be associated with an increase in overall consumption.

The pub life: consumption up by 50%

Lung cancer rates soar for women in industrialized nations

By Thomas Land

GENEVA — Lung cancer mortality has increased by 300% in Canadian women, says the *Weekly Epidemiological Record* published by the United Nations World Health Organization (WHO).

The survey concludes the disease is replacing breast cancer as the chief cause of cancer deaths among women in industrialized countries.

The rise in lung cancer death rates of women in the past two decades has been particularly steep in English-speaking countries, plus Denmark, says the WHO.

A spokesman describes lung cancer as a "self-induced, avoidable, and preventable tumor."

He adds the new findings "clearly indicate the need to establish fresh priorities and strategies on cancer control."

A 20-year survey published by the WHO earlier this year revealed an enormous increase in lung cancer mortality in women, estimated at 200% in 28 industrialized countries including Canada (**The Journal**, May).

Further analysis related to the countries with the highest lung cancer death rates has now led to a revision, putting the age-adjusted increase at 200% in Britain, Australia, Ireland, and New Zealand and at 300% in Canada, Denmark, and the United States.

"This may well reflect an earlier breakdown of social taboos against female smoking in these populations, particularly in the English-speaking countries," comments the WHO.

The statistics also show mortality more than doubling in Norway, Sweden, Poland, and Japan.

There are two noteworthy exceptions: female mortality from lung cancer in Denmark has risen much more rapidly than in other Scandinavian countries, and death rates in Scotland are far higher than in other parts of the United Kingdom.

During the 1960s, mortality from breast cancer worldwide was up to seven times greater than from lung cancer.

But, the WHO report adds: "In recent years, this ratio has declined to about 1.5 — and indeed, in Scotland, the death rate from lung cancer is now identical to that from breast cancer.

The same trend is already discernible in Canada, the US, Britain, Denmark, Ireland, Japan, and New Zealand.

Although mortality varies from country to country, women between the ages of 55 and 75 years are most affected.

Mr Peanut would be surprised, or a case of mistaken identity

TEL AVIV — An original, if time-consuming and clumsy, way to sell and smuggle hashish on a crowded street has been devised by a drug pusher here.

The dealer, who thought he had found a foolproof method against being caught, laboriously opened the shells of pistachio nuts, removing the contents and replacing them with hashish. He then glued the two halves together.

He was caught when a woman who really wanted pistachio nuts was mistakenly given doctored nuts and went to police. Officers not only found the "laboratory," but also quantities of hashish from Lebanon, shipped by water to the Gaza Strip and smuggled into Israel.

New Books

by MARGY CHAN

The Law and the Treatment of Drug- and Alcohol-Dependent Persons

. . . by L. Porter, A.E. Arif, and W.J. Curran.

This publication is part of the World Health Organization's continuing review and analysis of legislation and health matters.

The purpose is to analyze existing legislation on the treatment of alcohol and other drug dependent people in selected countries, in order to assist member countries in reviewing their own legislation and in determining whether revision is needed. Legislation enacted up to 1982 in 42 countries and one territory (Hong Kong) is included.

The result is this comparative study of the relevant legislation, guidelines for assessing how existing legislation functions, and suggestions for alternative approaches to the development and review of national legislation. The book is concerned primarily with how legislation promotes the treatment of people who are dependent on alcohol or other drugs and on an analysis of the legal provisions governing treatment program administration. It also contains a summary of legislation and a bibliography.

World Health Organization, Geneva, 1986. 216 p. Cdn $29.33. ISBN 92-4-156093-2.

Northern Spirits: Drinking in Canada Then and Now

. . . by Reginald G. Smart, Alan C. Ogborne

Alcohol problems have existed in Canada from pioneer days. By tracing the history of drinking and drinking problems through the Temperance movement, to the Prohibition period, to the present day, the authors show how alcohol and its problems are wrapped up in both Canadian history and present-day social life.

The book covers different complexities of the alcohol issue in Canada: alcohol consumption, social and psychological factors affecting alcohol use, drinking among Native people and in the north, alcohol production, taxation and controls, effects of alcohol policies, and some possible benefits of alcohol consumption.

The authors comment on what is typical about Canadian drinking and Canadian attempts to deal with the problem. The book ends with suggestions for further work in specific areas of research, treatment, prevention, and education.

Addiction Research Foundation, Toronto, Canada. 1986. 191 p. $16.50. ISBN 0-88868-129-1.

COMMENT

GILBERT

Unprofessional conduct

The anti-smoking movement and I have generally been on good terms. We agree on most things: that smokers die prematurely on account of their habit, that public smoking is public menace, and that the world might be a better place without tobacco.

We've disagreed over a few things too.

Most of the disagreements have been friendly, but one — concerning tobacco advertising — has caused grief.

When I argued that the Toronto Transit Commission should not ban tobacco advertising on its vehicles and property but, instead, surcharge it and use the proceeds for counter-advertising, I was given a special award for my ignorance, in front of television cameras summoned for the purpose.

Arguments against banning tobacco advertising are met with zealous resistance mindful of the response to blasphemy in a church. Respectable academics make outrageous, unsupportable, and misleading statements against tobacco advertising in a manner quite different from their ordinary professional demeanor.

Governments, in my view, should deny freedom of speech in three cases only: when there is a pressing national interest, such as an ongoing war or imminent natural catastrophe; when libel has been proved; when restriction (not prohibition) is required to ensure the freedom of speech of another person, or to protect minors. Preventing free expression in other instances probably causes more harm than the harm the prevention is designed to avoid.

Thus, you find me parting company with the anti-smoking movement on the matter of banning tobacco advertising. I part company with my feminist friends on banning pornography. My usual inclination toward intervention by government is absent on matters to do with freedom of expression. "I disapprove of what you say, but I will defend to the death your right to say it," Voltaire was said by a biographer to have said. A good philosophy, I think, whoever the source, and however reprehensible the beneficiary.

Advertising has its special controversies. "Advertising, in its spirit and purpose, is germinal fascism," has been one opinion. "Without advertising, it's Russia," has been another. More moderate have been the views that "You can tell the ideals of a nation by its advertisements," (Norman Douglas), and "Advertisements contain the only truths to be relied on in a newspaper," (Thomas Jefferson). I like Stephen Leacock's definition of advertising: "The science of arresting the human intelligence long enough to get money from it."

Advertising empowers

Advertising, with all its banality and duplicity, is part of the sharing of information that empowers people. Banning advertising serves the status quo.

All this is by way of saying that those who strive to ban tobacco ads make me peeved, however noble their cause. Even if their case were sound, I would be perturbed. The banners (those who would ban) would sacrifice the most essential feature of our society to secure a legitimate, important, but secondary interest in public health. But their case is not sound. The weight of evidence does not support a case that advertising tobacco products contributes to the overall use of those products by any class of persons.

The combination of a weak case and inexplicable zeal pushes the banners into disturbing behavior that deserves exposure. I shall dwell here on some of the chicanery and dissimulation that passes for academic and professional input into the vital debate as to whether tobacco ads should be banned altogether.

The debate is heating up, particularly in the United States, where legislators are under pressure to ban and where 20 to 30 suits filed by individuals (or their estates) in respect of smoking-related diseases are currently wending their way through the courts. Each plaintiff seeks compensatory and punitive damages for personal injury or wrongful death. A claim in many of the suits is that tobacco advertising contributed to the disease, that there was a conspiracy between tobacco companies and advertising agencies to mislead the public, and that false and misleading information was knowingly distributed. An aim in many suits is to force tobacco companies to place stronger warnings on their products and cease using advertisements that link smoking with youth, virility, and health.

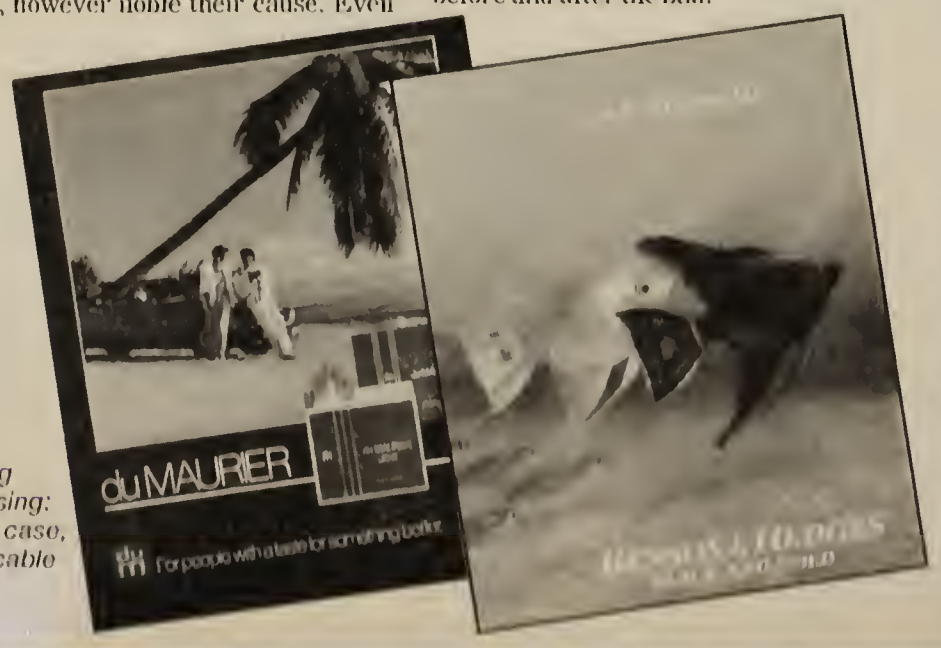
. . . I shall dwell on some of the chicanery and dissimulation that passes for academic and professional input into the vital debate as to whether tobacco ads should be banned

Congressional committee

Representations were made to a subcommittee of the US Congress in July. The four that I have read were by Kenneth Warner, chairman of the Department of Public Health Policy and Administration at the University of Michigan; Ronald Davis, for the American Medical Association; Virginia Ernster, associate professor of epidemiology at the University of California; and, Alan Blum, founder and chairman of Doctors Ought to Care (DOC) and former editor of both the *Medical Journal of Australia* and the *New York State Journal of Medicine*.

These four presentations are riddled with wrong and misleading statements. Let me begin with Norway.

Two of the deputants mentioned Norway. Banners love to cite Norway. Tobacco advertising was banned in Norway in 1975 and, by one measure, consumption declined. But by this measure, consumption was declining before the ban, and so it is perhaps more correct that the decline caused the ban than to say the ban caused the decline. By another measure, consumption remained pretty much the same before and after the ban.



Banning advertising: a weak case, inexplicable zeal

But, see what Dr Davis said: "In both Norway and Finland, there are fewer persons using tobacco now than when these countries allowed advertising . . . a reduction in the number of persons who use tobacco is precisely the effect expected and desired from an advertising ban."

Dr Warner said: "There is no question that this overall campaign was effective — a persistent growth pattern in smoking ceased instantly and smoking immediately began to decline, particularly among teenagers." These statements are blatantly misleading.

What about wrong 'facts?' Here are four the professional banners tried to perpetuate:

• Drs Blum and Davis both said cigarettes are the most advertised product in society. I don't have US figures at hand (none was cited by either expert), but the proportions are likely similar to Canadian figures that put tobacco products a poor third or lower, far behind beer and automobiles.

• Dr Ernster repeated the often-heard argument that cigarettes are the leading preventable cause of death in the US. I suspect that automobiles rank higher. A 10% reduction in gasoline use in California during the fuel crisis of 1974 was associated with a 10% reduction in overall mortality. A similar reduction in tobacco use would be associated with only a 3% reduction in mortality. Therefore, gasoline (ie, automobiles) may very well be a more important preventable cause of death. (But, you might say, automobile use is not preventable in the same way as smoking. It is.)

• Dr Ernster, and also Dr Warner, said that women started smoking in large numbers *after* they were targeted in cigarette advertising. Historical analysis, described in detail in my August, 1985 column, shows that women started to smoke in large numbers *before* the manufacturers began to appeal to them, largely because newspaper reports made it acceptable.

• Dr Davis said, ". . . Tobacco use extracts an annual economic cost of about $65 billion, or roughly $2.17 for each pack of cigarettes smoked in the country." But, he cited an estimate that looked only at one side of the equation. Tobacco use brings economic benefits. The usually-cited benefits — employment and economic activity — are relatively minor, compared with the bonanza smokers give society in the form of their premature deaths, consequent release of stored resources, and removal of society's costly obligation to provide for them in old age. If reducing health costs is the only objective, smokers should be encouraged to continue their habit. Over their lifetimes, they will probably cost the community less as smokers.

Unsupportable statements

When the four experts were not garbling the facts, they were mostly making unsubstantiated and unsupportable statements about the effects of tobacco advertising. Here are some examples:

• "Cigarette advertising recruits new users . . . creates social acceptability for smoking . . . re-stimulates individuals who have quit to start again . . . helps reinforce the complacency of those who do not smoke" (Blum).

• "Tobacco product advertising and promotion encourage individuals to start using tobacco, reassure users, and entice former users to resume tobacco use" (Davis).

• ". . . Cigarette advertising and promotion do affect consumption . . . the case for a relationship between advertising and smoking is quite strong" (Warner).

There is virtually no evidence to support these assertions, certainly none in the four presentations.

Some of the experts' remarks were fatuous, such as the statement by Dr Warner, "if advertising did not increase consumption, there would be no reason for a state tobacco monopoly to advertise. Yet, each of the following countries has a state monopoly and cigarette advertising: Austria, Japan, South Korea, Thailand, and Turkey." Canada's first, sixth, and 15th leading advertisers are the governments of Canada, Ontario, and Quebec, respectively, all of which are monopolies in their areas of enterprise.

An underhand tactic of banners is to introduce as 'evidence' statements alleged to have been made, usually anonymously, by employees of tobacco companies and their advertising agencies. Dr Blum said an "advertising man" told him: "When I worked for (a well-known New York advertising agency), we were trying very hard to influence kids who were 14 years old to smoke. . . . The entry age is 14. I was laughing on the outside and crying on the inside. My experience tells me never to believe any noble notions about advertising men — that they won't take aim at kids. They will aim at whomever the client and they have determined will sell (sic) the product. They do not care what the product is."

Dr Warner urged the subcommittee "to contemplate the words of a representative of the tobacco industry, a marketing employee of Brown & Williamson:

"Nobody is stupid enough to put it in writing, or even in words, but there is always the presumption that your marketing approach should contain some element of market expansion, and market expansion in this industry means two things, kids and women. I think that governs the thinking of all the companies." This is the tawdriest kind of evidence — unreliable, untraceable, and probably unrelated to the issue. Its use by accredited academics is unconscionable.

Regrettably, these four professionals are not alone in their lapses from ordinary academic standards when dealing with the issues around tobacco advertising. A cursory review of the literature reveals an unfortunate abundance of misreporting, misrepresentation, illogical argument, wild generalization, and old-fashioned inaccuracy. Let me mention just one, mild example.

Wild generalization

The book by Dr Benjamin Singer of the University of Western Ontario, *Advertising and Society* (1986), contains a chapter entitled, The paradox of promotion: the advertising of alcoholic beverages and tobacco. Dr Singer's conclusion is that "For the most part, critics of the advertising of alcoholic beverages and tobacco products have succeeded in proving their points. Despite industry denials, advertising does increase sales."

But, this statement follows a review of the literature that overwhelmingly shows the opposite for alcoholic beverages and provides no evidence concerning tobacco.

Next month, I'll look closely at evidence on the effects of tobacco advertising, such as it is, and discuss related issues, notably the worrying claim publishers suppress adverse information about tobacco to avoid offending their advertisers.

By Richard Gilbert

NEWS AND COMMENT

Group shakes off the stigma of lacking 'clout'

MADD taking a political activist role in US

By Terri Etherington

EUGENE, Oregon — A new wave of professionalism may be changing the thrust of the United States-based, citizen activist group MADD (Mothers Against Drunk Driving).

More men and more families are getting involved, says Steven Ungerleider, PhD. And, local MADD chapters are beginning to shift their orientation toward criminal justice intervention and away from dealing only in public education and awareness.

Dr Ungerleider and colleagues from Integrated Research Services here surveyed 212 MADD chapters, 63.1% of the 336 valid US chapters.

While the survey showed MADD groups continue to place strong emphasis on prevention and education, more members believe the most effective deterrents are legal sanctions.

Dr Ungerleider told **The Journal** there is a sense chapter leaders are "frustrated. They would prefer to be more involved in the criminal justice system.

"They are perceived as MADD mothers and carry the stigma of not having clout."

This is changing, however, he said.

The researchers conclude: "After five years on the national scene . . . the thrust of MADD's work is no longer just to tell the victim's story but to change attitudes and behavior to prevent the creation of more victims.

"One might say the grief cycle (denial, anger, sorrow, depression, and acceptance) has come full circle. MADD has come to accept its role in the community as a vehicle for citizen activists who want to effect social change."

Survey results also indicate chapters with a higher proportion of male members tend to have more program involvement and stress a wider variety of community efforts.

There was 48% support for rehabilitation as a solution for drinking/driving problems. More than half (52%) did not consider 'safe rides' a solution, arguing the program "might encourage people to drink and then face the critical decision of whether to drive or call for assistance."

Dr Ungerleider and colleagues say the shift in emphasis suggests, "MADD has emerged from its honeymoon status with the press and is now moving into a systems approach involving multiple components of community resources to deal with the drunk driving dilemma."

Consumption drops, profits rise

By John Carroll

FREDERICTON — Despite reduced overall consumption of beverage alcohol, the sales and profits of the New Brunswick Liquor Corporation (NBLC) increased again in fiscal 1985/86.

This prompted a renewed call for a set percentage of profits to be allocated to the annual budget of the province's Alcohol and Drug Dependency Commission (ADDC).

The annual report of the NBLC shows that in the year ending March 31, 1986, revenues totalled $195.8 million, up 2.1% on the $191.7 million made the previous year.

Profits increased by 4.3% or $2.9 million, to $70.1 million from $67.2 million in 1984/85. Based on a 1983 New Brunswick population of 706,600, per capita expenditure on alcohol was $277.10. The profit represented 35.6% of gross sales.

Beer continued to be the beverage of choice, but the 51,090,250 litres consumed indicate a per capita decline of 2.34 litres to 70.93 litres. Consumption of liquor also decreased and at 3,445,758 litres declined to a per capita rate of 4.78 litres, from 4.98 litres.

Wine again showed a modest advance, with a per capita consumption increasing to 4.45 litres from 4.41 litres, for an annual total of 3,202,188 litres.

When the legislature's Crown Corporations Committee studied the report and questioned NBLC senior management, Liberal MLA Sheldon Lee said it was "shameful and disgusting" that liquor profits were about 3.5 times greater than revenues from two of the province's major economic sectors: forestry and mining.

Liberal financial critic Allan Maher moved that the committee recommend 15% of the profit of the NBLC be directed to the ADDC.

As in former years when similar motions have been made, this was defeated because the committee did not have a mandate to intervene in the budgetary process.

HOWELL

A letter to Richard Gilbert

January 1, 1987

Dear Richard

Thank you for your recent letter (**The Journal**, December, 1986). I too enjoyed our encounter, including the "too much time we spent discussing politics."

Your suggestion we switch roles — you trying your hand at humor and/or satire and me attempting to be serious and dull — does appeal to me, notwithstanding the fact I don't think I could use you as a role model for my new persona.

No offence, but I've read your column for quite some time, and, although I find it serious, I have yet to find it dull.

In any event, I have applied myself diligently to your suggested topic: the social benefits of the moderate use of drugs. I have been attempting to put together what you describe as "an intricate and well-researched estimation of optimal levels of drug use."

And, I have been feverishly searching libraries and electronic databases so that I can, as you suggest, demonstrate the consistency of my conclusions with reports in the anthropological and historical literature of societies that declined because of too little or too much drug abuse.

So far, I've only encountered one problem. Perhaps you can help me with it, since your research skills are obviously more highly developed than mine. The problem is this: there is precious little historical and/or anthropological literature about societies that declined because of too little drug use. Indeed, I have been able to come up with only three obscure examples:

• There is the case of the Chengu people, who occupied what is now the Changajn Nuruu region of central Mongolia between 1250 BC and 100 AD and left a variety of puzzling artifacts, including the famous 'Yinchuan Jade,' thought to be the inspiration for the modern 'Happy Face'.

Recent, computer-aided cryptoanalysis has greatly aided the decipherment of Chengu pictograms, and it now appears that the vibrant Chengu culture of the first millennium BC (the culture that produced the Yinchuan Jade) became dispirited and demoralized because of a decree prohibiting alcohol and other mind-altering substances put into effect by the emperor Chin Tuong (120-50 BC).

This decree eventually resulted in a situation in which there was no one Chenguans could feel superior to: before long Chenguan culture suffered from an absolute lack of a class of people the average citizen could look down on as depraved or morally weak.

Lacking an easily-identifiable social sub-group which they could vilify and ridicule, Chenguans were forced to look inward and contemplate their own moral failings. They got so discouraged they stopped making jade Happy Faces and were swallowed up without a fight and without a whimper in the expansion of the Han Dynasty of China, circa 200 AD.

• There is also the case of the Bithnyan culture, which flourished on the Anatolian plateau from 2500 to 300 BC.

Recently, expert linguists have deciphered a significant proportion of the cuneiform-like Bithnyan script, and it would appear that long before Pericles and long before the rise of Athens, Bithnya was a hotbed of democratic republican government: there were political parties, political conventions, even elections. These things apparently existed up until 405 BC and the rise of the demogogue Laodecia I, who issued an edict prohibiting the use of alcohol and coffee.

Following the Edict of Laodecia, Bithnyan democracy fell into total disarray. The noted scholar Giberin, in his classic, *Decline and Fall of the Bithnyan Empire*, suggests the Bithnyan republic disintegrated because of the Edict of Laodecia.

Alcohol and/or caffeine, argues Giberin, are essential fuels of the political process, since people who go to political conventions invariably consume one or the other — or both — in great quantities. Denied these essential fuels, says Giberin, Bithnyans simply lost interest in republican government and the democratic process.

So, it is not surprising, says Giberin, that Bithnya fell, after a half-hearted and desultory struggle, to the armies of Alexander of Macedonia in 356 BC and was never heard from again.

• And finally, there is the case of the Bunyoro people of central Africa (200-1200 AD). Well, perhaps I should say the alleged case of the Bunyoro people, since I'm trying to be serious and dull and there is a considerable body of scholars (Pritchard, Weismann, and Divot to name just a few) who have questioned the very existence of the Bunyoros, suggesting they belong to the world of legend rather than the world of archaeology.

(Weismann is very convincing on this point, and his argument that the famous Musetta Stone supposedly deciphered by Champignon in 1887 is an outright 19th century fake is not without merit.)

In any event, Champignon claims to have unlocked the secret of the curious Bunyoro hieroglyphs and says the Bunyoros had a highly developed literate culture. Around 1100 AD, references to a 'Flack' epidemic begin to appear in Bunyoro literature and banana-leaf broadsheets. Champignon says Flack was some sort of killer-herb which the Bunyoro scribes claimed was going to tear the fabric of Bunyoro society apart.

But, in fact, Flack was a minor problem confined to minority communities; even in those communities, it had a self-limited life span. However, the Flack-hysteria of the scribes served the interests of the Bunyoro rulers, who were anxious — as rulers always are — to divert public attention from more legitimate concerns, namely the poverty of the lower classes and the war-mongering of the ruling classes. So, the authorities encouraged the scribes.

I don't think I could use you as a role model for my new persona. No offence

The Bunyoros disappeared about 1150 AD. Pritchard says they were decimated in an ecological disaster; Bunyoro scribes were so obsessed with the phony, media-induced Flack-menace that they completely ignored the real menace: African killer bees.

So, there you have it, the sum total of my research into societies that declined because of too little drug use.

It isn't much. Indeed, having embarked upon this research exercise and having found it quantitatively fruitless, I am inclined to agree with Freiberg and Helwig, who assert in *Chemocentrism and Culture* that there is precious little historical and/or anthropological literature about societies that declined because of too little drug use. They say this is due to the warped perspectives of anthropologists themselves, who tend to ignore non-drug-using societies and focus their attention on the other kind.

As Freiberg and Helwig point out, everyone has heard of the famous Schleimman expedition. Everyone has heard how, in 1881, Baron Schleimman penetrated the upper reaches of the Amazon.

Everyone has read of Schleimman's encounter with the Xoxital tribe: how he observed the ritual smoking of the sacred 'Zatixuma' leaves, how he watched the frenzied drug-inspired dancing, how he saw the sacramental chewing of Itakha bark, how he — with mounting wonderment and horror — observed what happened to the Sacred Virgins, and how he and his six brave co-adventurers dodged the poisoned tips of Sacred Arrows and escaped to tell the tale.

Schleimman's tale of the Xoxitals is a classic of anthropological literature.

But, as Freiberg and Helwig point out, has anyone ever heard of the Yumblaba tribe, a tribe much more numerous than the Xoxitals, a tribe with which the exhausted Baron and his men spent five happy and recuperative months following their adventure with the Xoxitals?

Baron Schleimman dismisses the Yumblabas in two sentences. And, what was the Yumblabas' crime, why were they virtually ignored by Baron Schleimman? Was it because their idea of a good time was to gather together in front of their mud huts and sing — as a round — this song:

Row, Row, Row your dugout
Gently down the Amazon (literal translation, 'big stream')
Merrily, Merrily, Merrily, Merrily,
*Life is but a *&¢%,* (not yet deciphered)?

Freiberg and Helwig say Schleimman unconsciously chose to ignore the remarkable counterpoint and harmony of Yumblaba round-singing because of chemocentrism. Since he himself came from a drug-taking society, Schleimman was culturally preconditioned to dismiss the gentle pleasures of the Yumblabas as boring and culturally preconditioned to concentrate on the antics of the Zatixuma-smoking, Itakha-chewing, Xoxitals.

I think Freiberg and Helwig may have a point, and this may explain the absence of anthropological and historical literature that deals with cultures in which there was too little drug use.

Of course, I may be wrong; I'm new at this serious and dull business. Please advise.

Yours truly

Wayne Howell

By Wayne Howell

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Drink, Drunk, Drive

Number: 761.
Subject heading: Impaired driving.
Details: Three, 12-min filmstrips.
Synopsis: Drinking-driving accidents have reached epidemic proportions, particularly among young people. The problem has been compounded by lenient law enforcement. It is not only the victims who suffer, but also families and friends. The driver responsible suffers emotional trauma. There are ways to combat this problem. Organizations such as Mothers Against Drunk Driving (MADD) raise awareness and force changes in legislation. Young people can take precautions: not drinking too much, spacing and sipping drinks, and removing the car keys from impaired friends.
General evaluation: Good to very good (4.5). The filmstrips contain good information that could lead to valuable discussion about drinking and driving and ways to deal with the problem.
Recommended use: With a resource person, the filmstrips could benefit those 15 to 18 years old and their parents.

Smoking and You

Number: 756.
Subject heading: Smoking.
Details: Five, 10-min filmstrips with audiotapes.
Synopsis: Quality of life depends on decisions people make. Some decisions, like smoking, could make a great difference. There are many short- and long-term undesirable effects of smoking, and the best way to avoid this "dirty, harmful habit" is simply never to start.
General evaluation: Poor (2.2). This series overstresses the long-term effects of smoking, inappropriate for the young target audience. The issue of birth defects is raised but is insufficiently discussed. The filmstrips are boring.
Recommended use: None.

Staying Alive: Decisions About Drinking and Driving

Number: 753.
Subject heading: Impaired driving.
Details: Four, 10-min filmstrips with audio cassettes.
Synopsis: A tow-truck driver at the scene of a drinking-driving accident discusses how he feels about cleaning up afterward: a police officer explains he had stopped the car earlier to give the driver a warning; the parents and girlfriend of the dead driver share their feelings: and, the man who sold beer to the boy stresses he is not responsible. The filmstrips explain why it is dangerous to drink and drive and that being fit, drinking coffee, or sticking to beer will not reduce the chances of a drinking-driving accident. Viewers are urged to find out about groups such as MADD (Mothers Against Drunk Driving), SADD (Students Against Drunk Driving), etc to help combat the problem.
General evaluation: Good to very good (4.5). These well-produced filmstrips include good information on current intervention programs. Some reviewers were concerned the progorams discussed focus exclusively on drinking/driving and appear to tolerate underage and excessive drinking.
Recommended use: With a resource person, the filmstrips could benefit all audiences 12 years and older.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Ontario Psychiatric Association: Unity and Quality Care — Jan 21-24, Toronto, Ontario. Information: Pierre Beausejour, Rm 4418, dept of psychiatry, Ottawa General Hospital, 501 Smythe Rd, Ottawa, ON K1H 8L6.

Drinking and Drugs: Use and Abuse, A Multi-Media Distance Education Course — Begins Feb 2, Canada. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Addictions Foundation Atlantic Conference 87 — April 26-30, Saint John, New Brunswick. Information: Roger A. Alain, information officer, Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, NB E3B 5H1.

1st Pacific Institute on Addictions — May 5-8, Langley, British Columbia. Information: Karl Burden, Alcohol and Drug Concerns Inc, 11 Progress Ave, Ste 200, Scarborough, Ontario M1P 4S7.

PRIDE Canada 3rd National Conference on Youth and Drugs — May 14-16, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

United States

13th Annual Advanced International Winter Symposium: — Feb 1-6, Colorado Springs, Colorado. Information: Jeffrey D. Elliott, symposium coordinator, Psychotherapy Associates, 3208 N Academy Blvd, Ste 160. Colorado Springs CO 80907.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, FL 33069.

International Native American Solvent Abuse Conference — March 2-4, Tulsa, Oklahoma. Information: Travis Jackson, president, Native American Research and Technical Assistance Center, Inc, 411 E St, Seminole, OK 74868.

10th Annual Alcohol Symposium, Diagnosis and Treatment: New Perspectives on Old Dilemmas — March 7, Boston, Massachusetts. Information: Judy Reiner Platt, Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139.

12th Annual Regional Institute on Alcohol and Drug Abuse — March 10-11, Belton, Texas. Information: Central Texas Council on Alcoholism and Drug Abuse, PO Box 203, Temple,TX 76503.

PRIDE 1987 International Conference on Drugs — March 19-21, Atlanta, Georgia. Information: Jean Alford, National Parents' Resource Institute for Drug Education, Inc, 100 Edgewood Dr, Ste 1216, Atlanta, GA.

5th National Symposium on the Impaired Nurse — March 25-27, Atlanta, Georgia. Information: National Nurses Society on Addictions, 2506 Gross Point Rd, Evanston, Illinois 60201.

American Society for Clinical Pharmacology and Therapeutics Annual Meeting — March 25-28, Orlando, Florida. Information: Elaine Galasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

American Orthopsychiatric Association Annual Meeting — March 25-29, Washington, DC. Information: Marion Langer, executive director, 19 W 44th St, Ste 1616, New York, NY 10036.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism: Alcohol and Sports — April 23-26, Cleveland, Ohio. Information: Forum coordinator, NCA, 12 W 21st St, New York, NY 10010.

Abroad

Symposium on the Prevention of Alcohol Misuse Among Children and Young People — Feb 25-26, London, England. Information: Institute of Alcohol Studies, Alliance House, 12 Claxton St, London, SW1H 0QS

The International Congress for Alcoholism and Drug Abuse Counselors — March 13-21, London, England. Information: Tom Claunch, PO Box 210638, Montgomery, Alabama 36121.

7th International Conference on Alcohol Problems — April 5-10, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

3rd Annual International Industrial Alcoholism Symposium — May 25-27 Frankfurt, West Germany. Information: Sara Bilik, Symposium chairperson, Conecta Partners, Berger Strasse 211, 6000 Frankfurt 60 FRG, West Germany.

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ARF program helps early-stage problem drinkers

Warding off the crash: a success story

By Joan Hollobon

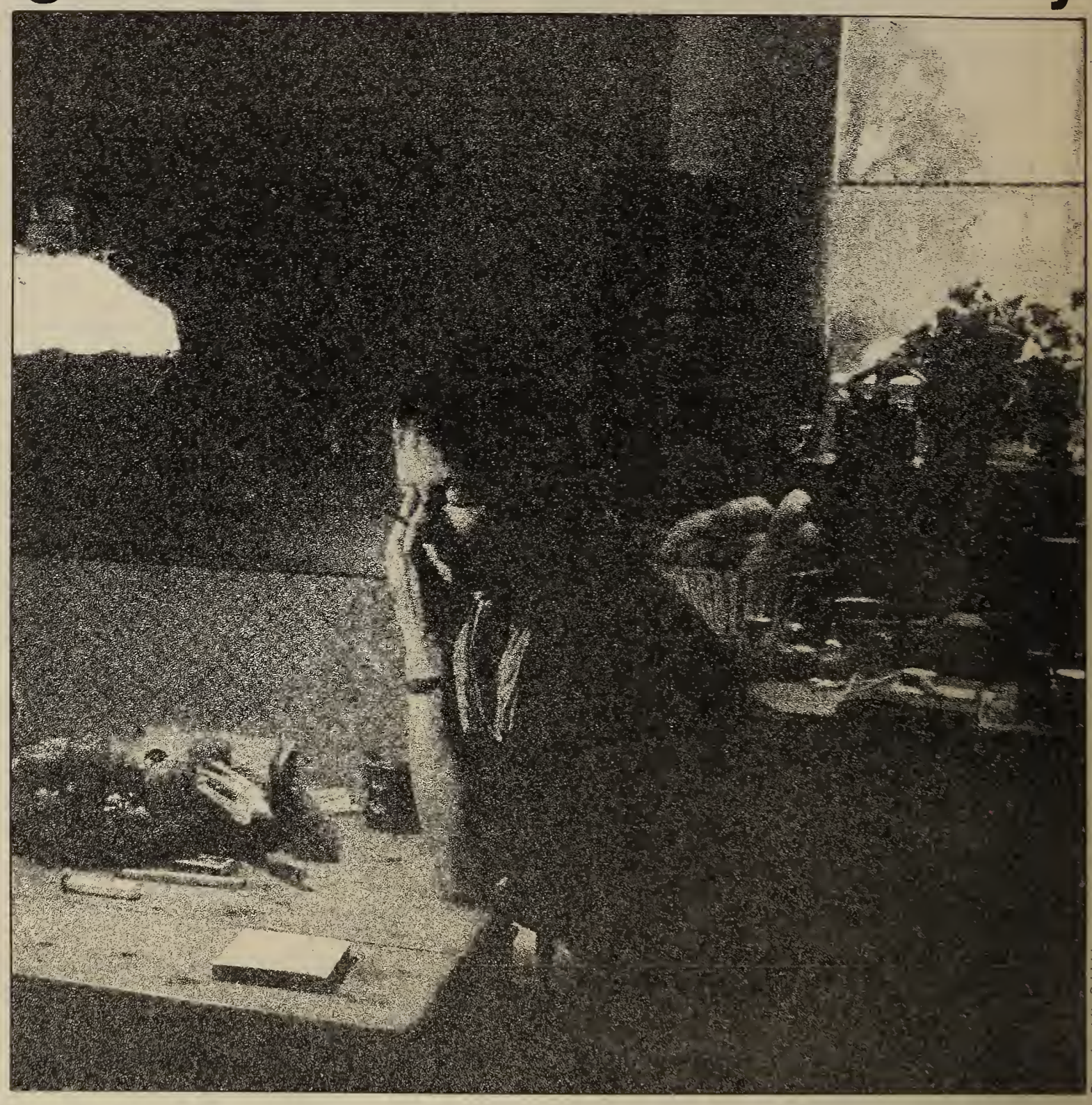


Photo of model by Golobitsh

TORONTO — Joanna is a striking woman in her 60s, European born, somewhat formal — a woman with "presence."

The morning she realized she could not remember her dinner party the night before was traumatic.

She remembered cooking it and serving it — another of the exquisite gourmet dinners she delights in preparing for her friends — but nothing more.

"My dinners are great; everybody loves to come and eat at my place. Everything was served properly, done properly. But then, 'What happened to that duck last night?' I couldn't remember eating . . . . My friends had noticed nothing, but I knew," Joanna told **The Journal.**

A successful business executive before her retirement five years earlier, Joanna did not take kindly to the thought of loss of control.

"I'd been in control of my life all those years; I was a manager for 30 years. . . . Something had to be done, but I wasn't sure what to do."

Alcoholics Anonymous was not for her, Joanna knew. She does not consider herself an alcoholic. She is not "a group person; I could never get up and admit I had problems." And, she was not prepared to be told, 'You can never have one more drink in your life.'

Then, by chance, she saw a newspaper advertisement from the Addiction Research Foundation (ARF) here announcing brief, confidential, outpatient treatment.

"I phoned right away. Martha was on the phone; we talked about an hour."

Martha Sanchez-Craig, PhD, is a pioneer of brief intervention for suitable, early-stage, problem drinkers as an alternative to the costly, traditional package of one-month of inpatient treatment plus one or two years of weekly follow-up (**The Journal**, September).

Dr Sanchez-Craig believes brief intervention is more effective for early-stage problem drinkers and that it is much more likely to persuade such people to come forward for help before they develop serious dependency and before they lose their jobs, their families, and their self respect.

The program is not designed for severe alcoholics but for people, like Joanna, with less than 10 years of excessive drinking.

It is essentially a learning process; it aims to teach people how to drink sensibly, to attain goals of controlled drinking set with their consent. The 78-page manual given each "student" sums it up: *Why not Drink Defensively? A Self-Help Manual for Drinking Safely.*

The course is no pushover. Dr Sanchez-Craig warns new students: "Abstention will be easier; one decision and that's it. With this, you must work at it very hard." The clients must answer detailed questionnaires, fill in daily records, and keep close track of their drinking. Commitment and honesty are prerequisites.

But, how does it feel for the new pupil?

A one-hour assessment interview for Joanna with "very friendly, very congenial people," was followed by three sessions, at two-weekly intervals, with ARF outpatient counsellor Carole Bush.

But first, 'one drink' was defined for Joanna, radically revising her awareness of how much she had been drinking.

Joanna's excessive drinking followed a distinct pattern; she drank almost entirely while she was cooking. Parties were no problem; she never drank in the morning, or after dinner.

But, about a year before she retired, she had fallen into the habit of pouring herself a drink as soon as she got home from work. After retirement, she continued to do so.

That drink sat beside her on the kitchen counter as she cooked. As the ice diluted it, she topped it up.

"When they asked me how many drinks I had, I said three or four. But, when I added up what they meant by one drink, I was drinking eight or 10 a day. . . . That's one thing you learn; you start counting, measuring," Joanna said.

(One drink is one shot of liquor — an ounce and a half — three ounces of sherry, five ounces of wine, or one bottle of beer.)

During the first two weeks, Joanna continued to pour a drink as soon as she came home from shopping in the afternoon, except now she took it into the living room and sat down to drink it. Later on, she had a second drink, again in the living room. Then, when she went into the kitchen to cook she poured herself a tonic water with lime or a similar non-alcoholic drink. She also took the alcohol out of the kitchen cupboard.

The next step was to pour a non-alcoholic drink when she came home. Later in the afternoon, she 'rewarded' herself with a sherry while watching television, and, when her husband came home, they had a drink together.

She began the program before Christmas a year ago, managing to get through all the Christmas and New Year cooking and festivities successfully. She rewarded herself with three drinks on her birthday at the end of January.

"But, I'm still fighting. Even now, when I'm in the kitchen, I'm tempted," she said.

Her friends had noticed her deterioration in the past few years and had expressed concern to her husband. Now, they have also noticed the improvement.

What did Joanna find the most useful thing about the course?

"Talking. Carole said, 'You are an intelligent person, do you have to do that?' No, I really don't. It's bringing it into one's awareness. And the counting business, that helped a lot. She told me to try some days not to drink at all, and I did it and I didn't suffer for it."

Joanna, a dedicated cigarette smoker, said she has never had a craving for alcohol. "Cigarettes — that is a craving. But, I don't have that problem with alcohol; it is just a stupid habit. . . ."

Even habits are extremely difficult to break.

Ms Bush told **The Journal** she prefers the word urge to craving. People often talk about craving as some "terrible thing that comes over them they can't control;" often these are really engrained habits.

"I say to people like Joanna, 'If you have an urge to drink when you walk in from shopping, then make the drink less accessible . . . . Often, we feel we must have a tea or a coffee when we are watching the television news. Is that a craving? To me, it's a habit."

Ms Bush: "Few people who come in here are really comfortable. It's my job to help them feel comfortable. They are here because they have a problem. I'm not here to punish them, I'm here to help them learn a skill.

"Many people have never learned the rules for drinking safely."

Often, clients do not know why they drink; sometimes, they have failed to realize that needing a drink to relax when they get home suggests they have not learned to handle stress on the job effectively, she explained.

The Sanchez-Craig manual instructs patients to assess their present drinking patterns and suggests different ways to achieve safe drinking, such as monitoring their own drinking, coping with pressure from drinking companions, substituting other activities for drinking, or coping with unhappiness or stress without reaching for a bottle.

Defining moderation, the manual says moderate drinkers do not drink daily, do not drink more than four drinks on any one day, seldom drink more than three times a week — and no more than 12 drinks a week — do not drink before noon, or use alcohol "as an important source of recreation."

Ms Bush said she always tries to have clients examine the differences in their behavior when they control their drinking. A businessman, for example, is clearer-headed in the afternoon, more productive — no more avoiding the secretary or chewing mints — and in better physical condition when he forgoes liquid lunches.

"Drinking is accepted so much — in business, in the golf club after the hole-in-one. It is easy to believe 'Everyone entertains their clients that way.' It is only later when people get out of the routine and look around that they find how many people are not drinking," Ms Bush said.

Criteria for admission to the ARF outpatient course include the absence of physical illness or concurrent treatment by a psychiatrist.

For most people, the program counselling suffices. But, occasionally, clients prove to have other problems and are referred elsewhere for marital, psychiatric, or psychological counselling, Ms Bush said.

She believes people are becoming concerned about alcohol abuse sooner today, "but they don't want to see themselves as alcoholic — a term I don't find very helpful."

Many heavy abusers who have already lost their social supports probably recognized early on that they had problems, but didn't know what to do about it, she said.

"I think it's marvellous that we are looking at early problem drinking and acknowledging there is a possibility of doing something about it in the early stages.

"We all see people and think, 'If only we could have gotten this guy 20 years ago before he'd lost everything.'

"I always feel more confident (of their success) when they come in the early stages," Ms Bush said.

THE BACK PAGE

ALCOHOLISM AND DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

Vol. 16 No. 2 2nd Class Mail Reg No. 2776 TORONTO, February 1, 1987

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Sports stars may be prone to cocaine deaths

By Harvey McConnell

LOS ANGELES — Top-class athletes are probably more at risk of death from a cocaine overdose because they are physically fit.

"Obviously, we shall never be able to prove that, but I think it is a valid hypothesis because of what we know about the actions of cocaine on the heart," says Forest Tennant, MD, drug abuse consultant to the United States National Football League (NFL) and Los Angeles Dodgers and director of a number of community health clinics in this area.

However, while cocaine overdose deaths of US sports stars Len Bias and Don Rogers triggered new federal anti-drug initiatives, the focus on cocaine should not obviate dealing with high dose alcohol and marijuana use and their much greater prevalence among athletes.

Elaborating on his hypothesis, Dr Tennant notes that "highly fit, highly tuned athletes may be more susceptible because they have more chemicals in their nerves, they have more highly tuned receptor sites, and they have something called an athlete's heart (hypertrophy) or thickening of the heart muscle.

"We know that cocaine restricts the coronary blood vessels to the heart (**The Journal**, August, 1986), thus reducing the oxygen supply to the heart, while at the same time it speeds up the heart as well as releasing norepinephrine which has a stimulating effect on the heart. You get several negative things working at the same time, and you can end up dying.

"Another way to die from cocaine is brain seizure, but you never know in cocaine deaths whether the brain seizure came before the heart stoppage or vice versa."

As for widespread marijuana use among professional athletes, Dr Tennant confesses: "It is a great mystery why anyone who wants to perform well in sports would ever touch marijuana, considering that one of the breakdown products stays in the bloodstream for from two to five days and may have some activity on the nervous system. It absolutely makes no sense."

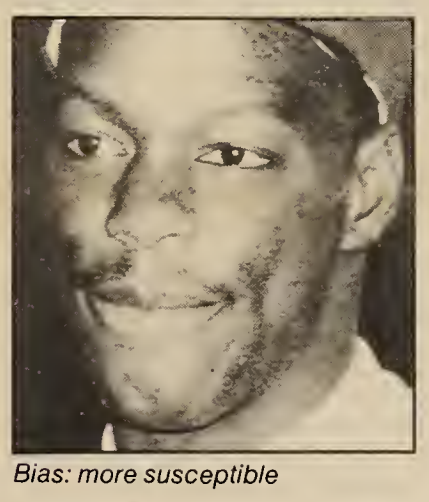
The most pronounced effect is on the eyes; the pupils do not react normally, and physical examinations find conditions known as nystagmus (involuntary eyeball movement) and strabismus. Marijuana also effects concentration.

The combination may explain why some players are error-prone, "because sports is really a matter of eye-hand coordination and constant mental concentration" (**The Journal**, January, 1986). The decrement, though small, wouldn't affect the average person but does affect the reactions of the top-class athlete.

Dr Tennant adds: "The evidence is that alcohol, marijuana, and cocaine all affect the high performer more than the average person.

"Why do athletes use marijuana? I think it is out of ignorance; they have been told it is harmless, it won't hurt you, and it is safe to use. All the evidence is to the contrary."

In his role with the NFL, Dr Tennant is involved in league plans to start testing players for anabolic steroid use when they report to training camps, or minicamps, under the present management-player contract which expires on August 1. Drug testing is expected to feature in the new contract to be drawn up between owners and players.


Bias: more susceptible


Tennant: out of ignorance

Rockers in Ireland for anti-drug videos

By Karen Birchard

DUBLIN — Some of the biggest names in pop music — all of them Irish —appear on an anti-drug video released here for use during the spring school term.

Megastars like Bob Geldof, Chris deBurgh, the Thompson Twins, and U2 perform their hits and also speak directly to the young people about drugs.

Mr Geldof uses humor and an appeal to students' vanity when speaking about heroin abuse, telling them one of the side effects is loss of hair.

"Your muscles go, your body falls apart — and so it doesn't matter if you're dead, you'll be bald. And that's worse."

Tom Bailey of the Thompson Twins tells young people: "The world is a great place with lots of things to do, but drugs will only close them off. Don't waste your time with drugs."

The video was the idea of a group of concerned parents, Community Action Drugs, who found it simple to get the video produced.

Chairman Grainne Kenny told **The Journal**: "Everyone I went to said it was a great idea, and no one wanted to be paid. I'm talking about everyone from the rock stars to the technicians and cameramen. They all felt it was important." (See **Ireland feature, The Back Page.**)

The video runs for an hour and features the stars on location here as well as their music videos. It will be shown in all Irish schools and in youth clubs.

Geldof: loss of hair

Bathroom technology advances

Urine-testers now offer privacy

By Harvey McConnell

WASHINGTON — A $10 digital thermometer and a "dry bathroom" can now eliminate the most objectionable aspect of urine testing for drug use.

"This way you can insure the sample has integrity and without direct observation, which people do find objectionable and understandably so," says Lee Dogoloff, executive director of the American Council for Drug Education here.

The concept is simple: the person being tested has the privacy of a bathroom, but there is no running water in the sink and a dye is added to the toilet bowl so water cannot be scooped up to dilute the sample. When the person leaves the bathroom, the temperature of the sample is tested with an inexpensive digital thermometer.

Mr Dogoloff: "That temperature better be close to what is inside your body. It has been found very difficult to duplicate because you can't keep a bogus sample in your pocket or under your armpit and get it to that temperature; the bogus one would be several degrees lower."

Mr Dogoloff, who lectures on the question of urine testing and whose council has sold more than 40,000 guides on how to test fairly, says: "By the nature of the technology, the test errs on the side of false negatives rather than false positives. The real concern is that some people talk about false positives — identifying someone as a user who is not — and that is highly unlikely, particularly if you have a good chain of custody."

Positive readings must be confirmed by gas chromatography and mass spectrometry.

"If you do that, you will not have false positives." But you will have false negatives simply because of the original cut-off levels: if it is 50 nanograms of THC (delta-nine-te- (See **Bootleg, p2**)

INSIDE

NEWS

Briefly . . .

The air you breathe

LONDON — A Norwegian scientist's observation that lumberjacks — who breathe in a lot of woodsmoke — rarely catch cold has led to development of a new drug to fight the common cold, *The Sunday Times* reports. Olav Braenden, PhD, a former chief of the United Nations narcotics laboratory in Geneva, combined vitamins B and C with polyphenols found in woodsmoke. Following tests on 300 Norwegian air force recruits, the drug has been approved, in nosedrop form, for use in Norway.

Hospital hospitality

DUBLIN — Patients in a new hospital planned for a town north of here will have their own on-site pub, following approval by the hospital board. This isn't a first for Ireland, however, *The Medical Post* reports. St Mary's Hospital in Castleblaney has had its own pub for some time.

Sign of the times

DELHI, Ont — Here, in the heart of Ontario's tobacco-growing industry, drivers travelling along Highway 3 may well light up a cigarette as they pass a conspicuous billboard. The sign, in four simple words, echoes the sentiments of tobacco growers, a reader reports in *The Toronto Star*. The sign says: "Thank You For Smoking!"

Lax diagnosis

BERLIN — Young women who abuse laxatives to keep weight down often manage to conceal their addiction from doctors, *The Medical Post* reports from the 18th Congress of the European Association for Gastroenterology and Endoscopy here. A United States physician, Gunter Krejs, said: "It is very important to be able to distinguish chronic diarrhea associated with laxative abuse from other causes." Dr Krejs of the University Health Science Center, Southwestern Medical School, Dallas, Texas, adds he and associates often search patients' hospital rooms for stashed laxatives.

Facing facts

MOSCOW — The number of Soviet drug addicts has risen 18-fold in two years, *The Globe and Mail* quotes the Kremlin as saying. Interior Minister Alexander Vlasov gave the new total as 46,000 in an interview in *Pravda*, the Communist Party daily newspaper. Last Soviet figures, released in May, 1984, had set the total at 2,500.

A glass of the best

BEVERLY HILLS — The latest addition to the bar scene on Rodeo Drive is H20, a watering hole that sells only water. A barely chilled glass of one of 50 bottled waters from Korea, Greece, Australia, Italy, Japan, and 15 other countries costs from one to two dollars, *Monday Morning Report* says. Imbibers are warned: don't ask for ice; it tends to dilute the flavor.

Regina program working on sleepers

By Deana Driver

REGINA — You can't sleep in class.

That simple rule has helped identify 150 cases of alcohol and other drug abuse in one Regina high school, with an enrolment of 350 students, in the past three years.

Herman Hovlund, regional coordinator of the Saskatchewan Alcohol and Drug Abuse Commission (SADAC), says school is the best place to start with a drug abuse program, "because school is the place where kids score their drugs."

SADAC began a program in the Regina high school in 1980/81 with the no-sleeping rule. If students slept in class, they had to see the principal or the guidance counsellor.

"The kid will always take the easy way out," Mr Hovlund told a symposium here, and choose the counsellor. For the second offence, the choice was the principal or a SADAC counsellor.

Mr Hovlund said SADAC has had workshops with 30 students taken out of the school setting. One student from each school clique was included, and these youths, when they went back to the school, talked about the problem in the hallways.

"As a result, we had seven kids come forward in the first week, and some moms and dads came forward," said Mr Hovlund.

Youths who do come forward are given professional assessments.

SADAC personnel are conscious of how they describe the problems of alcohol and other drug abuse within the school setting.

"We don't say the kids are on drugs. We don't say they're hooked. We like to use the words 'harmfully involved,' but often we don't even say that," said Mr Hovlund.

"We just say the kid is sleeping in class, and that's got to change."

It is often impossible to convince student athletes to come forward with drug problems. If caught, they are generally penalized instead of helped, and Jim Coucill, MD, a family physician and consultant to SADAC, said that attitude must change.

Drug abuse education must start at the 10-to-14-year age-level "when people are exposed" to drugs, said Dr Coucill.

Students should be told then not just to stay away from drugs, but "to have a responsible attitude if they do get involved."

There must be support networks for teenagers, and the education program should include components to build self-esteem, said Mr Hovlund.

It is essential to hold one workshop for the teenagers and then another one for the parents, so they all know the signals and consequences.

Dr Coucill said drug abuse is not one person's responsibility, but a community responsibility.

— Golobitsh photo

Wake-up call: eliminating sleep as an escape route

Smokey the Bear would love their rules

Two more schools smoke-free by June

REGINA — The public school board here has followed its Saskatoon counterpart, deciding smoking no longer will be permitted on any properties it owns or uses.

Saskatoon's board announced a similar policy in May, 1986. Regina's smoking ban went into effect immediately.

Board members voted to allow an eight-month transition period for smokers to adjust to the change in rules.

The board will provide staff and students with information about the health effects of smoking and second-hand smoke and will make a stop-smoking program available to those who want to quit.

Smoking will be restricted to designated areas until the end of May, with a total ban going into effect in the schools on June 1.

Members of the city council here have also recognized the dangers of smoking.

Recently, they passed a motion to discontinue cigarette advertising in all City of Regina facilities and on transit buses. The ban supports the city's efforts to achieve a smoke-free environment in public places.

Bootleg urine easy to detect: Dogoloff

(from page 1)

trahydro-cannabinol) in the sample and you have 48 nanograms, then you will be called clean even though you are not."

A major concern of Mr Dogoloff's, as use of urine testing increases, is not technicians starting "cowboy" labs in their basements or garages, but testing by laboratories designed to do general medical testing. These laboratories want to add drug testing as they would any other medical test.

He points out: "It is a specialized test which requires specialized handling and a chain of custody, as well as confirmation. The kinds of decisions being made may have implications in terms of the personal destinies of individuals, implications which are far different than if their blood sugar is a little high or a little low."

Dogoloff: no absolute rights

As for urine testing infringing on the individual's control of his or her bodily fluids — an issue raised by those objecting to testing, Mr Dogoloff has no doubts.

"It is a balancing of individual rights and public safety, and nobody has an absolute right to anything. The confusion is in trying to make it a moral issue: somebody's right to use and abuse drugs.

"That is not what we're talking about. What we're talking about is the safety of other people. People who are hurt most are not the drug users but those around them, their families, their co-workers."

As for the sale of bootleg urine for samples, Mr Dogoloff says those who might be tempted should beware.

"I have heard a number of stories of the entrepreneurial spirit in blackmarket urine. The only problem is the sealed container doesn't have certification by the Food and Drug Administration. What people have been buying is dirty urine eagerly supplied by drug users for a few bucks."

If levels of drug use in US society drop to pre-1960s levels, the question of urine testing should be reconsidered, he says. "But as long as the levels stay as high as they are and we have a vulnerability in our general population, it is here to stay.

"The question is to work it out in a way which is fair and reasonable and equitable."

— coming up in —

THE JOURNAL

- A week at the Addiction Foundation of Manitoba
- RCMP Estimate
- PRIDE Canada and PRIDE International conferences

NEWS

Many ex-smokers quit more than five years ago

Most Canadians smokers know they're addicts . . .

By Elda Hauschildt

TORONTO — One out of every three Canadians 18 years and older still smokes cigarettes daily, and 80% of them consider their smoking an addiction, a national poll indicates.

The majority of Canadians are non-smokers; they are divided almost equally between former smokers and never-smokers, Canadian Gallop Poll Ltd reports.

Eight out of 10 of the current smokers also say they smoke primarily out of habit, while only one in 10 smokes primarily for enjoyment. Other reasons given on the multiple-choice question include: to reduce tension (four out of 10), to be sociable (one out of 10), and for a "pick-me-up" (one out of 10).

The Gallop survey is based on a national probability sample of 1,046 Canadians interviewed in their homes between October 23 and 25, 1986. Results were released last month. The poll was sponsored by Merrell Dow Pharmaceuticals Inc, in collaboration with the Addiction Research Foundation (ARF) here and the Canadian Council on Smoking and Health, Ottawa.

(The 35% of adult Canadians now smoking represents approximately the same proportion recorded in 1983, a drop from the 50% who were daily smokers in the early 1960s.)

Kozlowski: no excuse

Ferrence: stat confusion

The fact that six out of 10 current smokers light up their first cigarette of the day within 30 minutes of waking is a measure of their addiction to nicotine, Lynn Kozlowski, PhD, head of behavioral research on tobacco use at ARF, told a press conference here.

But, said Dr Kozlowski, the key response in the Gallop survey is the 80% of current smokers who see their cigarette use as an addiction (see story below).

A majority of current smokers (71%) consider smoking to be "like drug addiction," and more/or as difficult to give up as alcohol (70%), coffee (66%), or going on a diet (66%).

When comparing smoking to the use of other drugs, fewer current smokers say it is more/or as difficult to give up as marijuana (36%), cocaine (21%), or heroin (18%).

Dr Kozlowski: "But, a survey we did at the ARF last year shows 75% of people with alcohol or drug problems say it would be as difficult or more difficult to give up cigarettes as to give up the drug they are having problems with."

The Gallop statistics also show an equal percentage of men and women smoke, but more women (65%) than men (44%) never start. This means more men (56%) than women (35%) are listed as former smokers, a fact that leads to confusion over the number of women who have quit smoking, ARF epidemiologist Roberta Ferrence explained.

"Statisties on women smokers show the numbers have been dropping since the mid-1970s," she said.

Ms Ferrence said more young people are current smokers; 42% of those aged between 18 and 29 years are daily smokers, compared to 37% of those between 30 and 49 years, and 28% of those 50 years old or older.

The survey shows people living in Ontario and British Columbia are less likely to smoke, while French-speaking Canadians are more likely to be current smokers.

Overall, 76% of current smokers are interested in quitting in the next 12 months, and 68% have already made a serious attempt to do so. "The more often you try, the more likely it is you will succeed," added Ms Ferrence.

There is some "slight self-deception" on the part of Canadian smokers about whether they are moderate or heavy smokers, she said.

The majority of current smokers (53%) call themselves moderate smokers and 28% say they are heavy smokers.

However, a cross-tabulation of these figures with data showing 31% smoke 25 to 49 cigarettes a day and another 6% smoke more than 50 cigarettes a day indicates 37% actually can be labelled heavy smokers (more than 25 cigarettes a day).

. . . But, butt out anyway, says ARF researcher

TORONTO — The high percentage of current smokers in Canada who view their smoking as an addiction (80%) is an indication that people have given in to special pressure to quit.

"And what we are left with is the addicted population," says Lynn Kozlowski, PhD, head of behavioral researeh on tobacco use at the Addiction Research Foundation here.

"This is what a 10-year-old British survey of 7,000 television viewers also showed; 51% of them had quit smoking for social reasons. Those who were left were addicted to nicotine."

Saying you are addicted is no 'easy out' to quitting, however, Dr Kozlowski told a press conference here announcing the results of a Gallop poll on smoking in Canada.

"Saying you are addicted to cigarettes doesn't mean you can't quit smoking. There is no drug addiction that a person can't overcome."

Dr Kozlowski said former smokers (91%) and current smokers (93%) alike know you have to quit when you are ready, not because someone else wants you to quit. He suggested smokers use their own willpower first to try to quit. And, if that doesn't work, they should use groups, consult with a physician, or use products designed to help them quit.

'Smoko' no more

AUCKLAND, NZ — New Zealanders commonly call a work break a "smoko," and the health department here wants to remove the expression from the language, replacing it with a healthier term.

"Calling your work break a smoko makes you think it's okay to sit in your tea-room filled with cigarette smoke," says the department's magazine, *Health*. "It makes you think it's okay for others to smoke their cigarettes in front of you.

"It makes you think that it's okay to smoke during your work break. It makes you think a break from work is a time for having a fag."

As a positive alternative to smoko, the department proposes using the word breather.

"When we take a break from work, we say, 'Let's take a breather.' So . . . why not take a breather!"

To relegate smoko to the status of outdated terms like chamber pot and perambulator, the department's district office in Palmerston North is launching a campaign.

INSIDE OUT

The latest conscript and me

I was walking away, headed for the table where the coffee waited, when I heard my name called out three times behind me.

Now, I have sometimes had the fantasy that precisely this was bound to happen, in the not very distant future, under just these circumstances, at an Alcoholics Anonymous meeting just like this one — crowded, lively, and upbeat — far away from the area where I lived.

I'd even rehearsed in my mind some of the bright, witty things I would say when I would turn around and recognize the person calling my name out.

I had made a mental list of possible candidates who'd be doing this calling out — a friend teetering on the edge of the cliff, poised to take the plunge into the Lake of Truthfulness about his addiction; an old hand I knew who had been straight for years and now seemed blessed with a peaceful imperturbability; or perhaps even somebody with whom I'd once spent one booze-soaked, drug-raddled night memorable for its take-it-to-the-limit awfulness, in another town, in another country, in another era, and had never seen since.

So I turned around, trying to be suave and easy about it all, about this little confrontation. I stopped dead in my tracks and didn't know what to say. I looked at the floor, and then I looked away completely, and, finally, I stammered out something really elegant and cool: "Uh, hi, how's it going?"

So much for my earlier rehearsals, I thought, laughing a little now as I went past some of the brothers and sisters on my way to give her a hug. At least I hadn't handled this meeting in the worst possible manner; I hadn't yelled out something along the lines of "What the hell are YOU doing here, anyway?"

No, I'd managed not to do that, thank God. Still, it was a shock to see this particular human being standing in front of me, beaming but awkward, all of a sudden as shy as a small youngster asking for a superstar's autograph down at the arena.

I felt exactly like a war veteran with a recruit, but the last thing I felt was any superiority

I had known this woman briefly, had even taken her out, once, and she had been aware then that I had stopped drinking. I recalled, as we stood now in the room where the brothers and sisters were huddling, that she had not had anything to drink the night we were together.

But another night, under precisely different circumstances, she had been at the same party I'd been at and she had gone over the line a little, I had heard later, when it was over and I had been long gone from the scene. Then, she'd gone away somewhere else altogether, and we'd never seen each other again, although I had thought of her once or twice.

Now she stood here. Several months had passed since we'd seen each other, and my mind raced backwards as I tried to remember if there had been any clues then, when I first knew her, that she would be the one here now, the one I'd rehearsed for. Of course, there hadn't been any clues at all.

Indeed, except for that party, where — compared to others who'd been there and truly had gone over the line — she had merely slipped slightly, she would have been one of the last people, really, I would ever have put on my mental list.

She had struck me as a classy woman, intelligent, responsible (she was a single parent with teenagers), humorous, and straight-forward. I liked her because she appeared to be competent, unflappable, in easy control of her life. And, she had a great laugh charged with irony and a well-developed realism about people.

So there I was — thinking I knew people so well, better, in fact, than I'd ever known myself — and I was sinking deep into that great, truthful cliché that we never really know about people, that we can never pin them down like butterfly specimens because they surprise you every time, and that anything is possible, always and forever.

"It's been five days," she said. She stopped then, pausing, thinking of what she'd just said, mulling the words over like a taster seriously considering an intriguing young wine, full of promise.

Then she said: "I haven't had anything now for five days."

She said it with a hush, the way you or I would tell someone else we'd won a gigantic lottery or been awarded the Nobel Peace Prize. She said it as if we were in a cathedral up by the altar.

We sat next to each other at the meeting. I looked at her out of the corner of my eye, as the speakers went on. I started trying frantically to look back at what it must be like for her — five days! — to be sitting here with strangers, in the strangest situation she'd ever faced.

I felt exactly like a war veteran with a recruit, but the last thing I felt was any superiority. The last thing I felt was like giving her was any advice, any cheap nostrums. She had to find the high road back herself. It was a bitter truth — she had to do it for herself, had to want to do it, and, then, the help and love of others would surround her and she'd be amazed.

I only wanted to tell her she was going out now on the longest, most spectacular voyage of her life, an odyssey that would make other previous trips as dull as a trek across the road to a grocery store to get milk.

But I couldn't even tell her that: words, anyone's words, couldn't do the job.

When it was over and the speakers had packed up their phrases and reminiscences and we all went to find our coats to go, I looked at her and merely wished her good luck.

And when I got home, I said a prayer for her.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

Pancreatic tissue damage from smoking

Cigarette smoking results in direct damage to pancreatic cells. But, researchers at the Veterans Administration Medical Center, East Orange, New Jersey, were unable to show a similar link between histologic changes in the pancreas and coffee-drinking habits. These results, which strengthen the likelihood of a relationship between smoking and pancreatic cancer, came from the evaluation of 22,344 slides of pancreatic cells taken from 560 autopsied subjects. Oscar Auerback, MD, and Lawrence Garfinkel found a spectrum of histologic changes linked in a strong dose-response relationship with smoking habits. While only 5.4% of non-smokers had medium to high percentages of pancreatic duct cells with atypical nuclei, this rose to 50.7% in light smokers, and to 74.9% in subjects who had smoked 40 or more cigarettes a day. Moderate to advanced hyaline thickening of arterioles seen in 12.8% of non-smokers increased to 74.4% in the heaviest smoking group. As part of their conclusion, the researchers say the thickening of blood vessels seen in smokers' pancreatic tissue "must have some deleterious effect, and, if truly widespread in many organs, it must put a strain on the entire cardiovascular system."

Digestive Diseases and Sciences, October, 1986, v.31:1014-1020.

Acetaminophen overdose prediction

A formula for accurately predicting the acetaminophen (eg, Tylenol) levels in an overdosed patient has been developed by Massachusetts scientists. The formula could be of clinical value in assessing the relative severity of the overdose. It involves a pharmacokinetic equation of absorption and elimination following a single oral ingestion. The researchers, from several pharmacologic and medical facilities in Boston, tested the formula's efficacy retrospectively with 44 adults who suffered acute acetaminophen overdoses in a 22-month period. A total of 80 drug levels drawn from the patients up to 16 hours after taking the overdose were evaluated. To control for decreased drug absorption as a result of vomiting or the use of a variety of treatments, only the first available concentration in patients who had not vomited or received any decontamination treatment, prior to drawing the level, was used. After applying the formula, the researchers found a statistically significant relationship between the measured and calculated levels. The report concludes it may now be possible for a clinician to accurately predict the measured serum acetaminophen level in a patient seen at any point in time from two to 16 hours after ingestion.

Annals of Emergency Medicine, November, 1986, v.15:1314-1319.

Disulfiram studies faulted

A large-scale United States study has questioned the efficacy of using disulfiram (eg, Antabuse) to treat alcoholics. Researchers from nine Veterans Administration medical centres conducted a randomized, controlled, blind study of disulfiram treatment in 605 alcoholic men. The patients were divided into three separate treatment groups and received either the traditional disulfiram dose of 250 milligrams, a dose of 1 mg of disulfiram (a quantity not sufficient to produce a disulfiram reaction), or no disulfiram. All received counselling. Bimonthly treatment assessments were done for one year with interviews with patients and relatives or friends (patients living alone were excluded from the study) and blood and urine analyses used to evaluate abstinence. There were no significant differences between the groups in number of patients totally abstinent, time to first drink, and employment or social stability. The one significant difference found was that patients receiving the standard dose of disulfiram reported significantly fewer drinking days during the study period. For all groups, compliance with the treatment regimen was strongly associated with ability to maintain total abstinence. The researchers conclude: "We did not find disulfiram provided additional benefit to the treatment services provided at our nine clinics in aiding our patients to remain completely abstinent or in delaying the time to relapse."

The Journal of the American Medical Association, September 19, 1986, v.256:1449-1455.

Coffee and coronary disease

Heavy coffee drinkers have a two to threefold greater risk of developing significant coronary heart disease. While such a link has long been suspected, researchers at the Johns Hopkins Medical Institutions, Baltimore, Maryland, and the United States National Center for Health Statistics, Hyattsville, Maryland, have now shown a definite relationship in a prospective study. In the study, 1,130 male medical students at Johns Hopkins Medical School were followed for between 19 to 35 years after admission to the school. Questionnaires mailed to participants at five-year intervals detailed changes in personal habits, including coffee consumption and smoking. Three measures of coffee consumption — early adult consumption, average consumption, and most recent consumption — were derived from this information, and clinical evidence of coronary disease was recorded. Evaluation of the data shows subjects who drank five or more cups of coffee daily had an approximately threefold greater risk of developing coronary disease — myocardial infarction, angina, or sudden cardiac death — no matter which measure was used. After taking into account age, current smoking and hypertension status, and baseline serum cholesterol levels, heavy coffee drinkers were still seen to be more than twice as likely to develop coronary disease.

The New England Journal of Medicine, October 16, 1986, v.315:977-982.

Pat Rich

Drug problems extra burden for hearing-impaired teens

By Harvey McConnell

CEDAR SPRINGS, South Carolina — As director of the South Carolina Commission on Alcohol and Drug Abuse, Gerry McCord has developed as clear a picture as anyone of alcohol and other drug use and abuse.

But, there is always room for surprise, as he discovered when the director of the South Carolina School for the Deaf and Blind here told him: "My kids have problems with drugs and alcohol."

"I was shocked. These young people don't need another handicap, they can't afford another problem," Mr McCord told **The Journal**.

With assistance from the state commission, the local Spartenburg Alcohol and Drug Abuse Commission, spearheaded by Barbara Glenn and Thom Seymour, drew up a pilot program for the students, their parents, and the school's residential staff.

They drew on curricula from as far afield as Manitoba, as well as from the United States National Institute on Drug Abuse and the US National Institute on Alcohol Abuse and Alcoholism. They have completed a pilot program with 12 hearing-impaired students aged between 13 and 18 years but are still developing a program for the visually impaired.

Ms Glenn, a certified interpreter for the hearing impaired: "While we do deal with the disability of the students, it is not the highlight of the curriculum, although we feel as well it is something that needs to be addressed."

She said the major problems the hearing impaired face are lack of communication with families, lack of access to much of the media, isolation, lack of self-esteem, and a dependence for the most part on a visual means of communication — sign language.

"These kids also have a lot of distorted information they are getting from their hearing-impaired friends," she added.

Training of residential staff, who act as a surrogate family, is equally important. Even before the program began, but after they were trained, counsellors discovered six students already had alcohol and other drug problems. Two were sent for treatment at another facility.

Depending on visual communication: distortion and misinformation

As the school is residential and students attend from across the state, staff are able to involve the parents in prevention and education only once or twice a year.

Ms Glenn said the aim is to enable students to set goals, make decisions, and make choices about alternatives to alcohol and other drug use.

Some students who live nearby leave the school on weekends, and all are at home during the summer. This means they may be exposed to drugs, and, as many work or receive allowances, they have the money to purchase them.

Mr Seymour said the program curriculum has been developed so it can be used on a state level and replicated elsewhere.

"We realize we are pioneering here. It may hit the mark. We feel we have gotten pretty close, but it is being refined.

"Whatever we do will be adapted and changed as time goes on."

He said there is no question of not talking about drugs with the students: "You can't have a non-use model or preach non-use without talking about the issue and all the communication issues that become a part of that. If you exclude any population, hearing-impaired or any other special population, I think you have enhanced the problem, not helped it."

Mr Seymour said a number of positive things happened in the school community after the program was initiated, including a rewrite of school policy.

"We found, for example, that people in psychological services had very little training in alcohol and other drug abuse, education, or prevention, or even how to counsel an addict or a child whom we call harmfully involved. We had to train these people much as you would elementary school guidance counsellors."

After this training of counsellors was completed, the six students with problems were identified immediately. Mr Seymour said he does not consider impaired students at higher risk than their peers, but that being in a residential setting could have an effect.

"They are close-knit folks. They would be susceptible if the leader in the community used drugs. They would be much more susceptible to peer pressure than a normal adolescent who might have several leaders in a large community to draw from.

"I think we have headed off a lot of things immediately in this school, but long-range effects of the program will only be known in five or 10 years from now."

Saskatchewan honors Saul Cohen

REGINA — Saul Cohen, MD, chairman of the Saskatchewan Alcohol and Drug Abuse Commission (SADAC) and founder of the Physicians at Risk Committee of the Saskatchewan Medical Association, is one of five people who has been awarded the Saskatchewan Award of Merit in 1986.

The award recognizes outstanding contributions to the social, economic, and cultural well-being of the province.

Dr Cohen, who is also active in private practice, became involved in SADAC in 1959. He has written the *Physician's Manual on Alcoholism* and is a charter member of the teaching program on chemical dependencies at the University of Saskatchewan's College of Medicine.

Cohen: contributing to province

Naval chemist gets brig for fentanyl production

WASHINGTON — A research chemist at the United States Naval Research Laboratory here was 80% of the way to manufacturing 300 grams of 3-methyl fentanyl worth a billion dollars when he was arrested.

Most of the evidence in the case against Hillel Hodes, PhD, has been kept secret after he pleaded guilty following his arrest. He was later sentenced to 15 years in prison and will serve his term at a "distant institution" under an assumed name.

Dr Hodes told investigators after his arrest he had a prior conviction in Massachusetts for manufacturing LSD. Experts said he knew what he was doing in manufacturing the fentanyl which would have been 1,000 times more powerful than heroin.

Dr Hodes claimed he started to stall because he feared when he delivered the fentanyl to trafficking connections, he might have been killed.

Earlier in the year, US Drug Enforcement Administration agents bought more than 10 ounces of methamphetamine from Dr Hodes.

COMMENT

GILBERT

Tobacco ad debate continued

This is the second of two columns on tobacco advertising. I noted last month how moves to ban the advertising of tobacco products are intensifying, especially in the United States (see letter, p6). The US Congress is under pressure to ban; many suits are before US courts claiming tobacco advertising contributed to the ill-health or death of plaintiffs or their estates.

The point of the first column was to vent my spleen against academics and clinicians who abandon ordinary professional conduct in their claims about the effects of tobacco advertising. I singled out four who made representations to a US Congressional subcommittee in July, 1986. They adduced hardly a mite of evidence among them. Instead, the four let loose a wealth of unsupported and unsupportable statements and downright inaccuracies.

Here I shall look more closely at the arguments against tobacco advertising. There have been three:

- Tobacco advertising should be banned because it increases consumption of tobacco products, directly or indirectly, especially among children.
- Tobacco advertising should be banned as unethical in that it promotes use of a product that causes disease and death.
- Tobacco advertising should be banned because it contributes to the suppression of accurate information about the hazards of tobacco use.

Under scrutiny

Hardly one piece of evidence produced by those who would ban tobacco advertising stands up to scrutiny. I mentioned the favorite item last month: the Norwegian ban in 1975 that was followed by a decline in the use of manufactured cigarettes. The decline began before the ban. Overall tobacco consumption has not fallen. Self-made cigarettes are now smoked more because of large tax increases on manufactured cigarettes. The ban had little bearing on this trend.

Consumption in Italy has increased substantially since advertising of tobacco products was banned there in 1962. The banners rarely mention this fact.

The banners have pointed to positive correlations between expenditures on advertising and cigarette consumption, claiming the former caused the latter. The correlations are not always positive. Where they are, as in advertising directed at women and women's smoking, a good case can usually be made that the consumption increase came first: the tobacco manufacturers were following the market, not leading it.

The banners say cigarette advertising must influence adolescents because it links smoking with desirable attributes such as toughness, friendliness, confidence, attractiveness, and enthusiasm. There is new evidence that these linkages occur, but none that they cause smoking. There is evidence too that 10 and 12 year olds are cynical about tobacco advertising. Here are some of the things Dr P. P. Aitken of the Advertising Research Unit of the University of Strathclyde, Scotland, and two colleagues reported young people as saying about a Marlboro advertisement in a 1985 article in *Social Science and Medicine*:

Cowboys, to get more people to buy them — do what the cowboys do" (10-year-old boy).

It's trying to get you to buy cigarettes" (10-year-old girl).

"Good background, scenery; good feel, got character to it. Shouldn't advertise cigarettes" (10-year-old boy).

"I like the horses and the scenery, but I don't like the advertising for cigarettes" (10-year-old girl).

"Rubbish" (12-year-old girl).

"I don't see what horses have to do with cigarettes" (12-year-old boy).

The recent experience of the RJR McDonald company with its ill-fated Tempo cigarette is instructive.

Tempo cigarettes were launched in September, 1985 with what may be the only cigarette advertising campaign aimed directly at young people. Even with a price discount, Tempo captured no more than 0.5% of the market. By May, 1986, negative sales were recorded: eg, more unsold stock was returned to the company than new stock was sent to retailers.

David Sweanor, lawyer for the Toronto-based Non-Smokers' Rights Association, said the failure of Tempo illustrates the rule that the "ads that most affect young people are the ones that associate adult smoking with the adult behavior young people aspire to." A company representative said the problem was the price war that started just after Tempo was launched. Who knows?

Careful studies of the initiation and maintenance of smoking in children point consistently to three contributing factors: smoking by parents and older siblings, peer pressure, and proneness to deviance in the emerging smoker. Advertising has not been shown to play a significant role.

Hardly one piece of evidence produced by those who would ban tobacco advertising stands up to scrutiny

Indeed, much cigarette advertising may be negative; Tempo's ads may have been especially effective in this way. Counter-productive advertising is well known in the industry. David Ogilvy, the doyen of Madison Avenue, noted as much in his 1983 book, *Ogilvy on Advertising*. He told the story of the head of marketing at the Ford Motor Company who put an ad in every other issue of *Reader's Digest* and found that readers who had not been exposed to the advertising bought more Ford cars.

William B. Foege, president of the Board of Trustees of the US American Medical Association, was quoted in February, 1986 as saying ". . . it's absolutely unethical for [tobacco companies] to be promoting tobacco, knowing what it does."

The same can be said for the following:

- automobiles — which kill a lot of people through accidents and pollution,
- food — the regular use of which by North Americans may account for more illness and deaths than tobacco,
- plastic products — whose manufacture and disposal can be life-threatening,
- electricity — the production of which is usually an environmental hazard, and
- weapons — which may be legally advertised in both Canada and the US and which kill or maim all their victims, but which seem not to cause fulminations in the medical establishment.

"Advertising is being made into a scapegoat by tobacco opponents," wrote J. J. Boddewyn of New York's City University in a thought-provoking chapter in the 1986 book, *Smoking and Society: Toward a More Balanced Assessment*, edited by Robert D. Tollison — a book I want to review here during 1987. Other commentators have noted advertising often acts as a lightning rod for critics of contemporary society who object to capitalism, industrial development, crass consumerism, etc.

Advertising as scapegoat

The perception of advertising as scapegoat, particularly tobacco advertising, helps explain how arguments against it persist in spite of their factual or logical shortcomings.

Even if the case that tobacco advertising is unethical is conceded, there may still not be reason to ban this advertising, for banning it may be more unethical. Statements about the ethical values of actions are useful only when made with reference to a hierarchical list of ethical principles. In my list, free expression comes ahead of freedom from risk, even free expression by tobacco companies.

If the banners could demonstrate to me that tobacco advertising reduces free expression, they may have a convert.

In his presentation last July to a US Congressional subcommittee, Alan Blum, MD, said: "The veritable absence of articles on smoking and cigarette advertising during the past 15 years in *Time*, *Newsweek*, and other magazines . . . is stark testimony to the power of tobacco advertising revenues to silence media criticism of the promotion of cigarettes." Dr Virginia Ernster said: "With the notable exceptions of *Good Housekeeping* and *Seventeen*, women's magazines receive tens of millions of dollars of cigarette advertising annually; perhaps as a result, they have largely ignored the subject of smoking and women's health in their editorial features."

There is a small amount of evidence for these assertions. It worries me. If it stands up to scrutiny, a case could be made for correcting legislation and a modest surcharge on advertising by tobacco companies with the proceeds being used to remedy the imbalance in information. A surcharge with the proceeds going to counter-advertising may not be such a bad idea anyway. A special charge on a certain kind of expression is a very different thing from a ban on that expression.

Dr Boddewyn made the point: "If advertising could directly, singlehandedly, and significantly affect aggregate purchases, horse carriages would still be with us." (He also wrote, "All the commercials in the world could hardly interest many people in wearing hairshirts or chastity belts.") Perhaps horse carriages should still be with us. Many advances in technology are less questionable.

Two possibly less questionable advances have been the filter cigarette and the low-tar filter cigarette. Use of both appears to have been influenced by advertising; countries with advertising have tended to use them more. In Sweden, where there is cigarette advertising, more cigarettes sold are filter tips and very many more are low-tar, both in comparison with Norway.

Some advertisements by manufacturers of alcoholic beverages, although self-serving, help in addressing some of the problems of drinking and driving.

Powerful message

A current ad by Seagrams seems powerful. Most of the text is a dialogue between a teenager and her father:

"Dad, you've got to help me."

"Sandy, what's wrong? Are you hurt?"

"No, Dad, I'm fine."

"Where are you?"

"At Pat's. We all came over here to celebrate after the game."

"It's almost 12:30. Isn't it time you called it a night?"

"That's just it. Remember you always told me if I was out never to drive with anyone who's had too much to drink? And not to be afraid to call you if I had no other way of getting home? Well, tonight I'm taking you at your word."

"Stay right there. I'm coming to pick you up."

"Thanks, Dad. Oh, and something else."

"Shoot."

"Are you angry with me?"

"Angry? No, Sandy. Not on your life."

Exceptions to the rule: other magazines profit from tobacco ads

By Richard Gilbert

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Editor... Letters to the Editor... Letters to the Editor...

'What information is shared in Benson and Hedges billboards?'

McDonald refutes Gilbert on tobacco ads

Richard Gilbert's Unprofessional Conduct column (January) is a misguided and arrogant attack on those of us who seek to ban cigarette advertising.

As author of a private member's bill now before the House of Commons to this effect and which would, as well, provide for a smoke-free work environment in places under federal jurisdiction, I would like to reply.

The problem is far more serious than Dr Gilbert admits. Yes, smokers die prematurely on account of their habit — an estimated 35,000 Canadians in fact. So also do nonsmokers die from secondary smoke, a point Dr Gilbert neglects to mention. The numbers are difficult to estimate, but probably are in the order of 1,000 Canadians per year — or more than there are victims of murder.

A considerable part of Dr Gilbert's column is devoted to showing errors in the arguments made by the advocates of a tobacco advertising ban. He may even be correct in his criticism, but this does not prove his point. If four — or 400 — experts make mistakes, this does not make a ban bad public policy, or not worth a try. The evidence is difficult to assess for nowhere has there been a complete ban and most partial bans have not been in effect long.

Smoking is still so much a part of our culture that it is widely portrayed, over-whelmingly positively, in books, films, television shows — even in productions of Shakespeare. Thus, even where "advertising" is banned, as in Norway and Finland, people see a great many positive images of smoking, quite apart from what they see in advertising *per se* in imported magazines and the like.

Dr Gilbert also castigates his four inexpert experts for not supporting their assertions that advertising affects consumption. Again, perhaps he is right, but what does this prove? Should we *not* make the attempt to discourage smoking because some researchers make their case badly? If the available research is poor, surely the point is to do some good research.

Some of Dr Gilbert's arguments are so inane as to insult his readers. Whether cigarettes are *the* most advertised product or third-most is surely irrelevant. That automobiles might be a more serious cause of death is also, even if true, beside the point. Here Dr Gilbert's "evidence" consists of reference to California statistics for 1974. (Incidentally, there is some evidence to the effect cigarette smokers have more car accidents than non-smokers, a point surely deserving of further investigation.) Dr Gilbert is offensive also in his argument that "if reducing health costs is the only objective, smokers should be encouraged to continue their habit," to save the community money. Whoever said costs were the only objective?

Dr Gilbert castigates the would-be banners for the "unconscionable" and "under-handed" use of the "tawdriest" evidence from employees of tobacco companies and their advertisers. These "unreliable" people have stated their employers are, in fact, out to get new smokers, especially women and children, contrary to the companies' line that they are only trying to preserve the market share of their brand.

Does Dr Gilbert believe the tobacco companies, these same companies who, for decades, denied there was any connection between smoking and lung cancer? Those companies used precisely the same tactics he is now using, finding flaws in the reported research and insisting that no association between lung cancer and smoking was sufficiently demonstrated.

The failure to distinguish the advertising of a product — a lethal product at that — from the issue of free speech is more serious. According to Dr Gilbert's criteria, government could restrict but not prohibit freedom of speech to protect minors. But how, practically, could this be done? Restrict tobacco advertising to $100 million per year instead of the $200 million currently spent? Get the ads to ensure that they affect adults only and no minors? How?

Dr Gilbert badly misses the point when he argues advertising is "part of the sharing of information that empowers people." What information is shared in the Benson and Hedges billboards, of large, beautiful, tropical fish? No information is conveyed in most cigarette advertising, rather, an image is created of an association between the product and good health, success, and style. Where is the information on tobacco's addictive qualities, the effect on cancer and heart disease, fetal development, and the dangers to women using oral contraceptives? Where is the evidence for Dr Gilbert's contention that advertising empowers and that a ban would serve the status quo? What freedom of speech does a health-conscious employee of an advertising company have in the preparation of a cigarette ad?

Citing Voltaire in support of permitting cigarette advertising is the lowest blow of all. Certainly Voltaire was a lover of liberty, although nowhere, to my knowledge, did he say "I disapprove of what you say, but I will defend to the death your right to say it." Voltaire, in fact, never chose death over censorship for his or anyone else's freedom of expression. He chose his battles shrewdly and on censorship preferred to change addresses than fight. In the great crisis over the *Encyclopédie*, Voltaire first counselled negotiation with the censor, through friends at court. Later, he urged abandoning the project and demanded the return of his correspondence.

McDonald: rescuing Voltaire

Voltaire's references to tobacco, incidentally, are wholly negative. He deplored the "new artificial need" that was being created, by example. Tobacco use itself was "dirty," "stinking," and "vulgar," evoking "horror and disgust." He noted, with no pleas for free expression, that tobacco was not permitted in the court of Louis XIV.

Voltaire was so much a fighter for the poor and oppressed that it is hard to imagine his putting any abstract cause, however noble, above the needs of real people. For this reason, it is difficult to imagine his siding with the defenders of pornography, another of Dr Gilbert's free expression causes. Voltaire was, after all, the great defender of the victims of torture. It is doubtful that he could have seen the rack and other instruments of torture as mere *objets d'art* for a person exercising his right of free expression in pornography.

Voltaire's views on liberty, finally, are germane to Dr Gilbert's arguments on advertising as "empowerment."

Liberty, for Voltaire, consisted of the power to act and choose "not to do the wrong thing when my mind represents it as necessarily wrong, to subjugate a passion when my mind makes me sense the danger." Liberty was a weak and limited faculty, which needed to be strengthened with reflection (*Oeuvres complètes*, 1876 ed vol seven, pages 26, 45-47).

Surely we know now that tobacco is addictive, destroying the mind's power to make choices and act in accordance with its sense of right and wrong.

My private members bill, C-204, under the new rules of Parliament, actually has a chance of being adopted. It was chosen by an all-party committee to be a votable item and is thus guaranteed adequate time in the House for debate. The bill has the support of the NDP (New Democratic Party) and Liberal caucuses and an unknown number of Progressive Conservative members. Minister of Health Jake Epp has so far refused to say whether he will support it. Three government members have spoken on this bill so far, two against and one in favor.

Lynn McDonald, MP
House of Commons
Ottawa, Ontario

(Ed note: Copies of bill C-204 may be obtained from Ms McDonald's office [postal code K1A 0A6]. No postage required.)

Howell slips on drugs, porn parallels

Wayne Howell's column on pornography (August, 1986) is, unfortunately, just another example of the pot calling the kettle black.

He ends by claiming, as if it were a fact, that under crackdown attempts J. D. Salinger's availability in the library is more likely to be affected than hard-core porn's availability.

However, there is plenty of documentation that porn's availability can be curbed and sex crimes with it, by doing no more than enforcing existing laws.

Nor is there actual evidence of "general success" of censorship of legitimate literature in the United States. Therefore, Dr Howell's last two sentences put him in at least as hysterical a category as the creators of *Reefer Madness* and *The Liberty Report*.

Finally, his criticism of the Meese Report conveniently omits — as do most of its critics — that one of its major conclusions is that the general nature and intensity of porn has changed significantly in the hard-core direction since 1970.

While the parallels between porn and drugs he points out are generally valid, I suggest he either stick with writing about drugs or do a better job on his homework.

John Kasten
Bangor, Maine

SPECIAL REPORT

Bike gangs:

Drugs, money, and the underworld

Beneath the popular image of free-wheeling bikers are groups of sophisticated, well-managed, organized criminals — the outlaw motorcycle gangs. A threat to any community they live in, the gangs have crime as their primary activity, from prostitution, to drug trafficking, to contract murder.

And, outlaw motorcycle gangs have reached a new and potentially more dangerous level through national and international activities.

Since the gangs discovered methamphetamine and PCP in the early 1970s, they have developed a lucrative market for the manufacture and trafficking of chemical drugs. They have prospered to the point they are now devoted to expanding their trade and maximizing their profits.

More than 800 outlaw motorcycle gangs have been identified in the United States — and 65 more are known in Canada. They vary in size from single chapters of five to 10 members to worldwide organizations like the California-based Hells Angels. There are three other major gangs: the Outlaws, the Bandidos, and the Pagans. The Pagans, the one group without international connections, are in decline since concerted law enforcement efforts in 1984/85 resulted in convictions for many of the leaders.

There are a variety of other outlaw gangs considered a serious threat to society: the Warlocks, the Vagos, the Dirty Dozen (in Arizona), the Gypsy Jokers (US Pacific Northwest), and the Sons of Silence (Colorado) are a few.

The following report is based on a joint research project of the Drug Enforcement Directorate, Royal Canadian Mounted Police, Ottawa, and the Office of Intelligence, United States Drug Enforcement Administration, Washington, DC.

The motorcycle gangs referred to are those labelling themselves the "1%ers," the percentage of the North American biker population the American Motorcycle Association in the United States estimates operate outside of the law.

The gang link with organized crime

As organized crime groups, outlaw motorcycle gangs in Canada and the US reject the laws and norms of society. They do know, however, how to use the law and judicial processes to their best advantage, utilizing expensive lawyers they have retained.

Changing with the times, gang leaders are more likely to be wearing three-piece suits than gang eolors as they go about their daily business. The gang president often plays the role of corrupter, whose function it is to establish communication with influential people and public officials, and the gang's sergeant-at-arms will take the enforcer role. Both these roles fit the accepted structure usual in organized crime.

Law enforcement groups are working to determine and document links between organized crime and the outlaw gangs, partieularly in the manufacture and trafficking of illicit drugs.

In fact, the major gangs have well-established links.

The Hells Angels chapter in New York city has a documented relationship with the Gambino erime family, and several chapters of the Outlaws have ties to traditional organized crime, aeting as enforcers and carrying out punishment or murders. The Pagans' association has been methamphetamine production and trafficking as well as enforcement.

Organized crime usually uses money to corrupt, with physical violence kept as a last resort. Outlaw gangs combine money and violence.

Organized crime operates within society, while outlaw gangs are detached. Both, however, have mechanisms to buffer leaders from law enforcement authorities.

The major outlaw gangs meet the US Department of Justice criteria for organized crime. The US National Organized Crime Planning Council restricts the term to "those self-perpetuating, struetured, and disciplined associations of individuals or groups combined together for the purpose of obtaining monetary or commercial gains or profits, wholly or partly by illegal means, while protecting their activities through a pattern of graft and corruption."

The council says organized criminal associations share these eharacteristies:

— their illegal activities are conspiratorial, using the definition that a conspiracy is an agreement between two or more individuals to commit a erime or to aecomplish a legal purpose through illegal action;

— they use violence, or the threat of violence, to intimidate. Outlaw gangs are notorious for this, possessing weapons and using a code of retribution against anyone they think has betrayed them. They keep dossiers on gang members and their families and intimidate witnesses and law enforcement authorities;

— they insulate their leaders from direct involvement in crime with intricate orga-

(continued on page 8)

SPECIAL REPORT

Bike gangs: Drugs, money and the underworld

(continued from page 7)
nizational structures. Law enforcement groups have found it easier to develop cases against individual gang members than against the gangs because of the insulated decision-making apparatus gangs use. Their code of silence also works against the police using counts against individuals members to develop conspiracy charges;

— they use corruption, graft, and legitimate means to try to gain influence in government, politics, and commerce. While they lack the political force of organized crime, outlaw gangs have started to show interest in using legitimate businesses as fronts for their criminal activities and to maintain links with politicians and law firms; and,

— they have economic gain as a prime goal, not just from illegal activities like drug trafficking, but also from laundering illegal revenues through and investment in legitimate commerce. The outlaw gangs are big business, owning or controlling businesses like motorcycle repair shops, catering firms, security services, entertainment agencies, towing companies, trucking firms, etc.

As they move toward legitimizing their activities, outlaw gangs have tried to sanitize their image through public relations campaigns. They join drives such as "Toys for Tots" to present a nice-guy image. More and more legitimate businesses are owned by the gangs, but illegal activities often result; many of their motorcycle repair shops, for example, are used to cover the interchange and sale of stolen motorcycles.

Unwitting investors are dragged in by the high rate of return on their money.

US situation

As closed social groups spread across wide geographic areas, US outlaw gangs are well-adapted to crime. Contraband and personnel can be moved easily along secure pipelines of supply and communication.

Drug trafficking accounts for the largest single source of revenue for the US gangs, who, in many areas, control the production and distribution of certain drugs, like PCP and methamphetamine. For example, state and local police report the gangs control at least 40% of the entire US supply of methamphetamine.

The outlaw gangs concentrate their trafficking in dangerous drugs — LSD, for example — because they can control the entire production and distribution process, from clandestine laboratories through street distribution. Such control offers security, lessens competition, and returns greatest profit.

Increasingly adulterated drugs are passed on to subordinate gang levels so that the drugs are cut and the money moves upward. Law enforcement agencies estimate that by the time the drugs reach the street, they have been diluted up to 500% and the price has risen 1,000%.

The US gangs are diversifying away from LSD, PCP, and methamphetamine. Their Canadian pipeline passes diazepam (eg, Valium) to the US, where it is used in the manufacture of counterfeit methaqualone. They import and distribute cocaine, marijuana, and — sometimes — heroin.

Major US gangs

• **Hells Angels**

Begun as a group for disenchanted World War II veterans in Southern California in the late 1940s, the Hells Angels have evolved into the most notorious of outlaw gangs, with 900 US members and drug trafficking as its prime source of income. It is emulated by other gangs, large and small. By the mid 1950s, charters were issued to other clubs, and by the 1970s, the gang was international through operations in Great Britain, the Netherlands, Germany, Denmark, Australia, and Canada. Today, other chapters also exist in Austria, Switzerland, Brazil, France, New Zealand, and Denmark.

Club policy decisions are still made in Oakland, California, although the New York city chapter has been prominent.

Large-scale drug trafficking began in 1967 when the Hells Angels became the main source of LSD in the US. Since the early 1970s, the gang has concentrated on producing and distributing methamphetamine and amphetamine, including nearly all of the supply for the US west coast. The club has diversified into cocaine, marijuana, PCP, and a wide variety of other illicit drugs.

• **Outlaws**

The most violent, major criminal organization in operation today is the Outlaws gang. The Outlaws' roots are in Chicago, Illinois in the late 1950s. They spread in smaller gangs throughout the Great Lakes region, the southeastern and southern US, and Oklahoma. Law enforcement intelligence indicates the leadership may be moving to Detroit, Michigan.

Because the gang is spread out, regional boards were started to coordinate local activities with national policy. Membership estimates vary from 1,000 to 3,000. National and regional leaders direct drug trafficking, relations with other gangs, and profit allotment for all chapters.

The Outlaws' non-drug criminal activities include extortion, contract murder, car theft, prostitution, and trafficking in weapons and explosives.

Most of their income is derived from drug trafficking, specifically diazepam, methamphetamine, LSD, and cocaine. Property they own in Florida is reportedly used to offload drugs smuggled by ship. Several motorcycle gangs, including the Outlaws, have shown interest in shipping Hawaiian marijuana to the eastern US.

• **Bandidos**

The youngest but fastest-growing of the outlaw gangs, the Bandidos are recovering from successful law enforcement efforts in 1985. Concentrated in Texas, the gang has approximately 33 chapters in the US (south-central and central states, Washington state) and one in Australia. There are four regional vice-presidents (one of whom is national president) and approximately 250 members.

Drug trafficking is also the major source of funds for the gang, but considerable revenue is generated by prostitution, arson, contract murder, fencing, extortion, weapons theft and trafficking, and welfare and bank fraud.

Established in 1966 in Texas, the Bandidos began transporting heroin as early as 1975. Methamphetamine is the drug most often produced by the gang. However, cocaine trafficking is on the increase.

• **Pagans**

Traditionally, the Pagans have controlled the manufacture and distribution of methamphetamine in the northeastern US. But, they are also involved in marijuana, cocaine, hashish, and diverted pharmaceutical distribution. A 1983-based estimate shows the retail value of PCP and methamphetamine the gang distributes to be in excess of US $15 million (Cdn $20.4 million) annually.

The Pagans originated in the Washington, DC area in 1959. Today, there are 500 to 600 color-bearing members and 34 chapters. The mother chapter has shifted from Baltimore, Maryland, to near Philadelphia, Pennsylvania, and is now in Long Island, New York.

Unlike the other major outlaw gangs, the Pagans run the chapters directly under the control of the mother group. Other illegal Pagan activities mirror those of other outlaw gangs, from contract murder, to prostitution, to arson

Inter-gang link

With each of the major gangs carving out a core area to control, conflicts develop in peripheral geographic areas. Often, the confrontation is violent, although relations between the major outlaw gangs are on a continuum from cordial to open warfare.

The strongest competition exists between the Hells Angels and the Outlaws, who have been virtually at war, especially in Canada, Ohio, and North Carolina. The belligerence extends to smaller gangs allied with the principals.

Law enforcement damage to the Pagans has led to a power vacuum in their area, and authorities expect conflict there.

Cooperation between the gangs is usually centered on drug production and trafficking.

Canada: an overview

Outlaw motorcycle gangs, says the Criminal Intelligence Service Canada, are one of the major organized crime threats in the country today, involved in various criminal activities ranging from murder to white-collar crime. The Canadian gangs are also diversifying into legitimate businesses.

Strategically located in Vancouver, British Columbia and border entry points in Ontario and Quebec, the Canadian outlaw gangs are in a good position to use club activities to cover illicit drug distribution. Their drug activities aren't confined to distribution though: Canadian gangs also handle the financing and manufacture of chemical drugs across the country.

Although they've also shown interest in cocaine and cannabis, they have little interest in the heroin trade, leaving that to traditional organized crime groups and other independents. In fact, use of any drug requiring injection is forbidden by the gangs.

Intelligence indicates that a number of Canadian motorcycle gangs are exchanging domestically produced amphetamine for LSD manufactured in the US. Methamphetamine is expensive and difficult to obtain in the US, but cocaine is cheap and plentiful. Trade in the two products had developed between gangs in the two countries.

Canadian outlaw gangs appear to prefer bulk buying of both cocaine and cannabis from known importers, rather than handling importation directly, however.

Canadian gangs

Canadian law enforcement intelligence sources say the Outlaws and the Hells Angels, of 65 existing outlaw gangs, dominate gang power in Canada.

• **Hells Angels**

The first Canadian chapter started in 1977, but Canadian activity went into high gear in 1980 when Quebec gang members travelled west, making contacts with other gangs, particularly the Satan's Angels.

The Vancouver Satan's Angels president met with the Hells Angels international president in Oakland, California, and a Canadian-US pipeline for drugs, weapons, and contraband resulted. The pipeline runs from the US through British Columbia, across Canada, to Quebec. Quebec-manufactured drugs are sent west to the US, and weapons and contraband are returned the same way.

Satan's Angels chapters officially became Hells Angels in 1983.

The Hells Angels now have seven Canadian chapters with Vancouver and Quebec as power bases. Canada is divided in half geographically: the western Canadian groups are run by the mother chapter in Oakland; Quebec and Atlantic province chapters are controlled from New York.

When the Halifax chapter was shut down by arrests in 1985, however, British Columbia gang members rotated two-week shifts to take care of chapter business from drug trafficking to prostitution.

Drugs — cocaine, cannabis, chemicals, and diverted pharmaceuticals, in particular — are the gang's principal income source.

In British Columbia, three chapters — two in Vancouver and one on Vancouver Island — are sophisticated and well-structured, using 40 registered companies to front the operation. Cocaine is the main product handled, with distribution networks reaching out into the prairie provinces. Intimidation, seizure of assets, and direct violence are used to collect drug debts.

Quebec gang members are involved in the manufacture and distribution of both methamphetamine and PCP and the distribution of cannabis and cocaine.

• **Outlaws**

The Hells Angels' major Canadian rival also started up in Canada in 1977, absorbing several Satan's Choice chapters. The Outlaws have three Quebec chapters and span an area from Quebec, southwest to Windsor, and north to Sault Ste Marie in Ontario. Chapters operate out of Ottawa, Toronto, St Catharines, Hamilton, and London as well.

The gang is prominent in smuggling and distributing diazepam and methamphetamine into the US.

Drug trafficking is only one income source for the chapter in northwestern Ontario; fencing stolen property, prostitution, extortion, and bootleg liquor are others.

• **Sultans**

Operating in Newfoundland, the Sultans have been heavily involved in marijuana and hashish trafficking. A combined law enforcement effort in Newfoundland, New Brunswick, Quebec, and Ontario in 1985, however, made the gang insolvent, with a drug debt of more than $150,000. Enforcement seizures approached a retail value of Cdn $1.6 million and eliminated the gang's suppliers and distributors.

• **Vagabonds**

Believed to be the most affluent outlaw gang in Ontario, the Vagabonds have a long-term membership (15 to 20 years) of 50. Cocaine is their big money-maker, although they have expanded into methamphetamine distribution in the Niagara peninsula area. The gang owns 50 acres of land in the Georgian Bay area and is on friendly terms with the Hells Angels of Nova Scotia for drug trafficking purposes.

• **Los Bravos**

• **Silent Riders**

These two Manitoba gangs are involved in cocaine and marijuana trade, with other Canadian outlaw gangs as their main suppliers. From 'have-not' clubs, the two have evolved into well-structured criminal organizations.

Methods of drug dealing differ between the two clubs: Los Bravos handle deals individually; Silent Riders sanction and finance transactions as a group. Each gang also has different outlaw gangs as drug sources, and rivalry between the two factions is expected to escalate until one dominates. The Hells Angels are expected to absorb which ever is victor and make Winnipeg a major centre for distributing illicit drugs and stolen motorcycle parts.

Future trends

The continued evolution of North American outlaw motorcycle gangs is expected to follow certain trends:

— developing working relationships among gangs in Canada and organized crime families, facilitated by such relationships in the US;

— an ongoing move toward legitimization, with closer ties to organized crime families and growing involvement in money-laundering by the gangs;

— intelligence gathering by the gangs targeted at rival outlaw gangs and law enforcement authorities;

— increased emphasis on physical and personnel security, using anti-intrusion alarm systems, attack dogs, radio scanning equipment, and communication networks;

— continued use of violence and intimidation as central to outlaw gang interaction with the outside world; and,

— increased travel, particularly first class air travel, by gang members.

Government working party had 'dreamy, romantic' vision

NZ experts, union fight liberalized alcohol laws

By Pat McCarthy

AUCKLAND, NZ — Radical liberalization proposed for liquor licensing laws here has alarmed agencies concerned with alcohol abuse.

Sunday trading, lowering the legal drinking age from 20 to 18 years, and allowing supermarkets and grocery shops to sell liquor are among recommendations made by a government-appointed working party.

It also proposed flexible licensing hours to be decided in each district by local councils.

But, the National Society on Alcoholism and Drug Dependence says opening up the liquor industry to increased competition would lower prices, increase consumption, and cause more social casualties.

The society's medical director, Geoff Robinson, MD, said representatives of the society's member agencies studied the report and declared: "We are alarmed and, in some instances, angered at the proposals. Our view is based on ease studies of those we deal with."

The director of the Alcoholic Liquor Advisory Council, Keith Evans, agrees with efforts to simplify the present licensing laws, but has expressed concern that the working party did not believe increasing the availability of alcohol would increase drinking problems.

While New Zealand's Minister of Justice Geoffrey Palmer praised the working party for a "practical, down-to-earth" approach, a liquor industry trade union accused it of a "dreamy, romantic vision" of drinking.

"Our members know the dangers of the product because they handle it every day and see the seamier side of its effects," said Rick Barker, Hotel Workers Federation secretary.

Working party chairman, former ombudsman, Sir George Laking said present liquor licensing legislation exists for the benefit of the alcohol industry, to limit competition. The working party suggests if the law is to help control alcohol abuse, the "economic regulations" have to be separate.

The government has called for public submissions by April 1, after which legislation is to be introduced.

But, given parliamentarians' conservative tendency on liquor issues (on which they traditionally have a conscience vote), it seems likely the proposals will be watered down before a new law is enacted, probably not until 1988.

Drinking games — alcohol as power

By Pat McCarthy

AUCKLAND, NZ — Long-standing social traditions encourage heavy drinking among New Zealand men, a health department study here says.

A crucial aspect is the connection between drinking and becoming a man, says Ian Hodges of the department's health services research and development unit.

His study of habits and customs associated with drinking encompassed hotels, sports clubs, stag parties, and beer festivals.

In one part of the country — the Otago region in the southern part of the South Island — he found more than 40 drinking games, with names such as One Fat Hen and a Couple of Ducks, Bottles, Hokonui Swindle, Fluffy Ducks, and All Blacks (named after the national rugby team).

"Many of the games, whether playful or not, appear to be a kind of proficiency test, based on people's success or failure with certain intellectual or physical challenges," he said.

"In fact, in most games, being forced to drink is a sign of defeat, not a reward."

Attitudes underlying the drinking games reflect the frequent emphasis of the adult entrepreneurial world that "social power belongs to those who can marshal control over others through alcohol," Mr Hodges said.

"Drinking games may mirror the hidden rules in less playful situations.

On one hand, we can see the invitation to drink and the exchange of drinks as a gesture of hospitality, a way of forming relationships.

"From another point of view, it can also mean achieving control over others, where the intimacy associated with drinking is combined with a battle for determining who drinks, where, and when."

Irish publicans declare war on price increases

By Karen Birchard

CORK — A call by the Irish National Council on Alcoholism for price increases on alcohol may be in for a rough fight, if recent actions by the country's pub owners are any indication.

Within days of the council's major conference to discuss a national policy to reduce the harmful effects of alcohol abuse (see The Back Page), Ireland's largest brewing concern announced a modest price hike.

Guinness made the surprise announcement on a Friday night in December, and, within hours, angry publicans were discussing how they could force the company to back down.

The price increase of four-pence on a pint (about seven cents Cdn) was front page news in every paper in Ireland that Saturday morning. Articles featured denunciations by the owners of licensed premises as well as sad comments from the men-on-the-barstools.

By Monday, the battle lines were drawn: pub owners in the west of Ireland decided to boycott Harp lager, one of the beers brewed by Guinness.

(Ireland is in the midst of a lager war and sales of Harp have dropped during the past few months. Pub owners thought they could force Guinness to change its mind by attacking a product believed to be vulnerable.)

The refusal to sell Harp soon spread throughout the country as the issue became the major news item, eclisping even the Irangate revelations out of Washington, DC.

After days of negotiations between Guinness and the Licensed Vintners Association, the morning papers carried banner headlines the following Friday: Guinness Backs Down on 4p Rise.

However, the price rose in the New Year.

Guinness said it had deferred the increase during the Christmas and New Year's season so that drinkers could enjoy their pints at the old price. But, they raised prices in mid-January, and another price hike is expected in mid-March.

Ireland's second biggest brewer of stout, Murphy's, has also announced a similiar plan.

Customs council on security alert

By Thomas Land

BRUSSELS — Officials coordinating a new strategy against drug traffickers have identified Lagos, Nigeria as the principal staging post for Pakistani heroin smuggled to the West.

Until recently, drug couriers had little to fear from airport customs there; Nigeria doesn't have a significant heroin addiction problem and flights to and from Lagos usually were not subject to rigorous drug checks.

The anti-smuggling strategy launched in June, 1986, links the world's airlines with the Customs Cooperation Council (CCC) in a new training and collaboration accord.

For the first time, flight personnel are involved in the forefront of a war against drug syndicates. Initial results have been spectacular: for example, cooperation among four countries has broken up a gang believed to have been responsible for the smuggling of £200 million (Cdn $408 million) of heroin from the Middle East to Western Europe and North America.

The case has pinpointed a security loophole at airports that enables smugglers to collect their wares — and terrorists to arm themselves — while awaiting their flights in transit lounges.

Drug smugglers and terrorists often try to confuse law enforcement agencies by using flights on which they are least expected; hence, the collaboration agreement reached by the CCC here and the International Air Transport Association (IATA) in Montreal (**The Journal**, October, 1986).

Says Gunter O. Eser, the IATA director general: "We are at war against one of the most insidious scourges facing modern society .... Only by combining our forces and determination in a spirit of cooperation will we be equal to the task."

The agreement, evolved by a working group of the two organizations, uses flight personnel in drug detection work. They are encouraged to watch for anything unusual, whether in the documentation of cargo or the behavior of passengers.

Airport muscle (above, Vienna's Schwechat): tackling traffickers in transit lounges

The current success of customs authorities against traffickers is largely due to the agreement with the airlines. Airline personnel now conduct drug checks on aircraft before — and sometimes during — flights.

The airlines have also agreed to develop a system — such as the use of accountable seals for example — for preventing the use of enclosed compartments in aircraft for concealing contraband.

And, they have promised to intensify checks on all areas and personnel under their jurisdiction, to provide practical assistance when customs authorities decide to search aircraft, and to inform them of any major changes to operational equipment.

Customs officials have been careful to acknowledge the primary responsibility of airlines is to move people and goods and that they cannot be expected to breach the laws, regulations, or control requirements of the countries in which they are operating flights.

But, they have promised to help the airlines review and upgrade security procedures by providing material assistance, specialist advice and training, as well as sensitive intelligence identifying high-risk flights.

Custom officials have also promised to assist airlines in ensuring that security and control procedures prevent unauthorized access to company facilities such as aircraft, baggage, mail, and cargo.

The Lagos connection seems to thrive on the principle of couriers switching destinations.

Since the start of the CCC-IATA agreement at Western European airports, more than 100 Nigerians have been arrested with heroin consignments packed in contraceptive sheaths and carried in their stomachs and anal and vaginal passages.

Several couriers have died from liver and kidney failure after condoms broke in their bodies.

Traffickers intimidating officials

WASHINGTON — Intimidation of judges and other Colombian government officials by drug traffickers through murder or death threats increases constantly.

Some prominent Colombians who fought against drug traffickers in the previous administration are now seeking an escape from terror threats by becoming ambassadors to Eastern Bloc countries.

James Knapp, United States deputy assistant attorney general, said: "The atmosphere of intimidation down there now is very, very serious, and we are very concerned about it."

The biggest fear is that the Colombian judicial system, which has a history of honesty, is going to be severely crippled by wealthy and ruthless drug traffickers. More than 60 judges have been killed in the past five years.

Threats that judges and their families will be killed have led to a number of trafficking suspects being released before trial.

NEWS

CoAs progress gradually to recovery

'Once it starts it keeps going'

By Karin Maltby

TORONTO — Adult children of alcoholic parents are spiritually frustrated and manifest their emptiness by spending their lives looking for love in all the wrong places.

This is the observation of Julie Bowden, a therapist in private practice in Santa Barbara, California, and co-author of several books on recovery for children of alcoholics (CoAs).

She told the 1st national conference here on CoAs that for most of their lives these people have been alone. "They've disconnected from their parents, from their selves, and they've disconnected from their higher power, whatever that might be."

Ms Bowden differentiated between CoAs first entering recovery and perhaps, eventually, connecting to the "second awakening:" they are "switching their orientation from their own healing back to the world and giving back what they have acquired. But, we cannot give away what we do not have."

She calls this second awakening in recovery genesis. "It is a perspective on life. It's a way of looking at life . . . . For someone, it might be the need to go to temple, for someone else it might be to study the Old Testament, or to have 10 minutes alone quietly.

"It might be spending a year working with Mother Theresa in India, or it might be going home to your community and making a presentation to your agency."

She said recovery for CoAs unfolds in a progressive and sequential way. "It almost seems as though recovery from this trauma is chronic, because once it starts, it seems to just keep going."

The first stage is survival. Young CoAs bargain with their higher power to get help and wind up feeling abandoned, Ms Bowden explained.

In the second stage, which she calls emergent awareness, CoAs recognize for perhaps the first time that their adult life is not working because of early years in an alcoholic environment.

Ms Bowden: "I consider emergent awareness the first spiritual awakening that occurs for a child of an alcoholic. Most of the time, I don't think it's called spiritual and I don't think it's called finding a higher power, or coming home to God. It's called hope."

When clients enter the third stage of recovery, they begin to deal with their own personal core issues.

"Children in an alcoholic environment have two choices: they can be right, or they can be safe. It is the safe child who makes it to adulthood. For safety, we train ourselves to put up with inappropriate behavior in our adult lives. We marry alcoholics; we put up with huge fights.

"As therapists, we must introduce the client to that safe child and be gentle with him as he lives through that age regression and remembers . . . . We need patience because we will have to model patience for our clients all the time."

Following the three stages is transformation, Ms Bowden said. Clients begin to learn new coping strategies and to put themselves first and prioritize their own needs for perhaps the first time.

"Transformations can take a long time. But, when most of the work is done, the person has stabilized his life. He no longer has weekly or hourly crises; he no longer has friends criticizing him for his own good, or has a job where he feels horrible. He then moves into the fifth recovery stage, integration."

When clients reach this point, they have times of joy, stability, and are living satisfactory lives, Ms Bowden said. But, for some people an event occurs that propels them into the sixth stage, genesis.

"This is where the recovery process can go. If (therapists) but know that, then they can at least signal it when the client seems to need the signal."

Bowden: needing the signal

Ms Bowden: "It doesn't mean taking them by the hand and doing spiritual counselling. You might just refer them on to someone who does spiritual counselling, or to a church or synagogue, or to a sunset.

"It's a lifestyle, and it needs to be reaffirmed regularly, just like health."

Now sniffers punch ping pong balls to get a high

By Harvey McConnell

WASHINGTON — Ping pong balls?

Gasoline additives, adhesives, cements, cleaners, coatings, de-icers, fuels, gasoline, hardeners, markers, octane boosters, paints, pens, polishes, chemical products, propellant gases, removers, sealants, paint strippers, cleaning supplies, thinners, and varnishes: none are a mystery to Robert Giovacchini, PhD, a vice-president with the Gilette Company and an expert on solvent sniffing.

But, he is always learning through the inventiveness of young people and what they choose to sniff.

He was interested then, when a young drug abuse counsellor asked him after a presentation at a United States National Federation of Parents conference here why many of his young clients said they got a buzz from punching a hole in ping pong balls and sniffing. Dr Giovacchini said he didn't know, but he would try to figure it out.

As vice-president of corporate integrity for Gillette, he has been involved for many years in the various ways and means sniffers sniff as well as methods of deterrence.

Sniffing is not new — the Greeks of Aristotle's day used to get a buzz by inhaling high volumes of carbon dioxide at natural springs.

In recent decades, sniffing took a deadly turn when young people started to inhale gas from air conditioning and fire extinguishers and then from aerosols, producing concentrations never studied before and which could almost instantly stop the heart.

It was the rise of airplane glue sniffing, still endemic in some areas, which pushed many industries into trying to make products sniff-proof.

A number of experiments showed oil of mustard would not affect the property of airplane glue, but would provide a jolt to sniffers.

"The new glue was introduced secretly into nine stores in Los Angeles. In only four days, about 90% of it was returned by youngsters, who claimed it didn't work," Dr Giovacchini said.

While oil of mustard was appropriate for airplane glue, it was not good for commercial adhesives, which the young also sniff, because it affected workmen who use the compounds daily.

In an attempt to make up labels to warn and deter young people, Gillette ran various trials.

"We found if we used the word intoxication it would attract young people. But, two words which did not attract were harmful and fatal.

"However, the words harmful and fatal certainly did attract our marketing department, especially the word 'fatal.' "

Dr Giovacchini explains there are three groups of sniffers: the experimental sniffer who won't try unless he is in a group and may not try again because of the odor, chemical taste in the mouth, or the severe headaches sniffing produces; the sniffer who sniffs as part of a group activity, and, the chronic sniffer.

Chronic sniffers are "youngsters who cannot face the day without being high."

Sniffing knows no bounds, geographically or economically; it's popular among Native North Americans, Pacific Islanders, and Australian aborigines.

And, even though some of the gases have been removed, aerosols still remain popular: this time the nitrous oxide in aerosol whipped cream and cheese cans.

Now ping pong balls have bounced onto the list.

More men are trying harder

WASHINGTON — More men than women are attempting to give up smoking, says a study from the United States Centers for Disease Control, Atlanta, Georgia.

A survey of smoking habits of residents in 21 states and the District of Columbia carried out in 1985 found "more men appear to be stopping smoking than women, even though the smoking hazards for both men and women have been widely publicized."

Some 25,000 current or former cigarette smokers took part in the study. Results show 42.3% of men attempted to quit, compared with 39.8% of women.

Meanwhile, a lengthy study of the evidence by a panel of experts gathered together by the US National Academy of Sciences says children whose parents smoke have a greater chance of respiratory ills. Non-smoking women married to a smoker have a 30% higher risk of lung cancer.

The report said the data are "remarkably consistent" that children whose parents smoke suffer from more wheezing, coughing, and sputum production than children from families where the parents do not smoke. Other possible effects on children could be increased risk of ear infection, decreased lung function, and possibly a slower rate of growth.

While conceding the magnitude of risks involved is unclear, the report says overall, "exposure to environmental tobacco smoke increases the incidence of lung cancer in non-smokers."

The experts were cautious about some studies suggesting exposure to tobacco smoke in non-smokers could reduce their lung function: adults in the normal course of life are at times, as well, in contact with substances which could reduce lung function.

HISTORY

'Users wising up for second time in a century'

Today's cocaine fears a replay of early 1900s

TORONTO — [It] is now getting more into vogue in Canada."

"[It's] the 'new craze.' "

"The use of cocaine is becoming so widespread."

"[I]t has grown to alarming proportions."

"[T]he profits made . . . are stupendous."

"This curse of cocaine has existed for a short time, but [i]t goes on spreading so fearfully that it is time for society to take a marked notice."

Remarks such as these can be found in almost any recent exposition of cocaine.

What distinguishes these statements is that they refer to a problem which plagued Canada in the first decade of this century. All of these reports are historical accounts of cocaine use whieh appeared in the popular press, the House of Commons Debates, and health profession journals in Canada between 1906 and 1910.

At that time, concern about the use of cocaine was voiced by politicians, church leaders, health professionals, criminal justice system personnel, and various moral crusaders. Cocaine was perceived as a problem that was "rapidly developing into a danger spot of threatening proportions" (*Canadian Pharmaceutical Journal*, April, 1908).

Although cocaine use was seen as a social problem in the early 1900s, contemporary writers tend to describe it as a new phenomenon. One reason, no doubt, is that the 1960s and 1970s are viewed as the time when drug use first became a widespread soeial problem.

Marijuana, hashish, LSD, MDA, speed, PCP, and cocaine entered the everyday vocabulary of a drug conscious era. Prior to this, illicit non-medical drug use was linked with particular, usually small, segments of the population.

In the public's mind, the Chinese opium smokers and the marijuana-using bohemians were the 'dope fiends.' The appropriateness of this perspective on drug use is called into question by examination of existing historical sources.

At the turn of the century, drug users could be found in most segments of the population because of the widespread and legal availability of patent medicines, beverages, and powders containing opiates and cocaine.

The problem of the 'cocaine habit,' for example, was raised in the House of Commons on November 25, 1910. A member of Parliament, citing a newspaper report, claimed that there were "thousands of men and women, many of them in respectable families, who are victims of the [cocaine] habit."

W.L. Mackenzie King, then Minister of Labor, subsequently described the problem of cocaine to the House. King quoted a letter from the chief of police of Montreal to indicate that "the Montreal police have made over 125 arrests . . . for selling or using that drug" in the last six months. King referred to an article entitled, *The Cocaine Habit Has a Grip on Ottawa*, which reported on the local cocaine traffic.

Furthermore, a probation officer was quoted as having met "as many as 50 or 60 little girls and boys within the same day, in the city of Montreal, all of whom had acquired the cocaine habit to some degree."

Mackenzie King (with F.D. Roosevelt): describing the habit to the House

A parallel exists between the nature and degree of the problem that appeared nearly a century ago and the one society confronts today.

A recent account indicated that "cocaine is now second . . . in popularity [to cannabis] as far as illicit drugs are concerned" (**The Journal**, April, 1985), and a 1906 report suggested that "with the speed at which the cocaine habit seems to be growing, [it] stands a good chance of soon becoming a close second [to morphine].

In the earlier period, cocaine's euphoric effects were first praised by a few and ultimately echoed and enjoyed by many. Within a few years, however, reports of cocaine's adverse consequences began to appear.

In this regard, it is interesting to note that a recent article in *Life* magazine closed with the following statement: "Today, the confessions of addicted celebrities and athletes and the advent of cocaine hot lines and detoxification centers are signs that the cocaine user is once again wising up — for the second time in a century of abuse."

Extracted from The Steel Drug — Cocaine in Perspective, *by Patricia Erickson, Edwad Adlaf, Glenn Murray, and Reginald Smart, published by Lexington Books, D.C. Heath and Co.*

HOWELL

The free market in ideas

Brave New World by Aldous Huxley, *Catch 22* by Joseph Heller, *A Clockwork Orange* by Anthony Burgess, *The Color Purple* by Alice Walker, *Death of a Salesman* by Arthur Miller, *A Farewell to Arms* by Ernest Hemingway, *East of Eden* by John Steinbeck, *Huckleberry Finn* by Mark Twain, *Lord of the Flies* by William Golding, *Nineteen Eighty-Four* by George Orwell, *One Flew Over the Cuckoo's Nest* by Ken Kesey, *Slaughterhouse-Five* by Kurt Vonnegut, *To Kill a Mockingbird* by Harper Lee, *Ulysses* by James Joyce, *The Shining* by Stephen King, and *The Catcher in the Rye* by J. D. Salinger: these are just a few of the books challenged, burned, or banned in the United States and Canada during the past 15 years because school or lending-library authorities felt they were "dangerous," "ungodly," "vulgar," "pornographic," and "obscene" and therefore a threat to the moral fibre of youth.

John Kasten, a reader of this column, has suggested (see page 6) I was being somewhat hysterical in my August, 1986 column when I said attempts to get Salinger's *The Catcher in the Rye* banned from high schools generally succeed. He may have a point because I don't know how many attempts have been made to supress *The Catcher in the Rye*. I only know about the successful attempts in De Funiak Springs, Florida; Issaquah, Washington; Middleville, Michigan; North Jackson, Ohio; and, Libby, Montana.

So, perhaps, I was being hysterical. And perhaps I was showing my age and the inclinations (that the written word is important) that go with it. Because, notwithstanding the machinations of school boards and library committees in the aforementioned towns, any kid between DeFuniak Springs, Florida and Morris, Manitoba (where *East of Eden* was banned from the school library in 1982) who is at all curious as to what subversive messages these relics of the Gutenberg age contain, can saunter down to the local convenience store and pick up a video adaption of the titles listed above, since every one of them — *Catcher in The Rye* excepted — has been made into a successful movie.

That's a kind of freedom (the ability to get access to alleged depravity by means of inexpensive technology) that is virtually unknown in many parts of the globe.

Consider the Soviet Union, for instance. In June, 1985, Communist Party chief Mikhail Gorbachev introduced an anti-alcohol law containing stringent measures to cut down on the consumption of alcohol: food stores removed liquor from their shelves, restaurants went dry, and liquor stores reduced hours of sale.

After a decade of portraying drugs as desirable, television gives equal time to other views

Of course, this experiment, in principle as noble as North American experiments with prohibition, eventually came to grief: faced with the wrath of a normally complacent public and a shortfall in government revenue equivalent to nine billion Canadian dollars (a shortfall that was a nine billion dollar windfall for bootleggers and home distillers), the government reluctantly eased-up. But not before a party review board, acting on the instructions of the Soviet Society for the Promotion of Sobriety, had arbitrarily cut drinking scenes out of 200 popular movies, withdrawn 60 movies from circulation because they celebrated or encouraged social drinking, and excised references to drinking in plays, operas, and literature. According to Sobriety Society spokesman Nikolay Tchernykh, only classics such as *The Brothers Karamazov* were spared.

Think of it. Drinking scenes cut from 200 movies, 60 movies sent to the Gulag, and a band of merry Sobriety Society Censors riding roughshod through the works of Turgenev and Chekkov, Borodin and Pushkin, cutting and prunning, snipping and excising, all in the interests of Public Health.

With all due respect to public health interests, would you want these characters to get their hands on *Casablanca*, substituting a 'Rick goes jogging' scene for the scene that ensues the night the Bogart character realizes Ingrid Bergman is married to another man? Would you want these characters to get their hands on *Under the Volcano*? On *La Traviata* (that drinking scene has got to go, catchy tune or no)? On any cultural property?

Despite the depredations of cultural vigilantes in the western world, it is important to remember they are vigilantes, and they do not represent The State. And for the most part, The State, to its everlasting credit, exercises a benign indifference in cultural matters. It is so benign that I can watch *Bedtime for Bonzo* on late-night television, a movie that shows Ronald Reagan, the president of the United States, playing second fiddle to a chimpanzee.

I doubt many world leaders — Margaret Thatcher and Mikhail Gorbachev included — would allow this kind of embarrassing business to go on. In the best interests of peace, order, and good government, not to mention public health, they would interdict, expunge, or proscribe films dealing with past simian shenanigans, literal or figurative.

What we have in effect, and what we should treasure even as we from time to time deplore it on individual moral and/or aesthetic grounds, is basically a free market in cultural goods. A free market in cultural goods is a clumsy and inefficient thing, but it is a far better thing than the Soviet alternative — which would assure that movies such as *Easy Rider* and books such as *Fear and Loathing in Las Vegas* would never see the light of day.

Because the free market in cultural goods or ideas — in lifestyles if you like — eventually rights itself in its own clumsy and inefficient way. We can see this in the film and television industries. After a decade of portraying drug consumption as a desirable exotic and/or erotic activity, both industries are now giving more than equal time to other views; *Miami Vice* portrays cocaine dealers as scumbags to be blown-away, the venerable Paul Newman in *The Color of Money* paints coke users as low-life deviants, and *Crocodile Dundee*, a low-budget sleeper from Australia, becomes one of the top-grossing movies of all times, despite the fact it ridicules the drug-taking habits of sophisticated New Yorkers.

The free market in cultural goods is not everyone's cup of tea. And even people like myself, who agree with it in principle, have trouble dealing with it in practice.

For instance, I am no fan of *Miami Vice* despite its 'get tough with drug dealers' message. I object to it because in the process of de-romanticizing drug dealing, it romanticizes violence. Much as I might wish that we could rid Florida of drug dealers, I don't really think that it should be done by machine-gunning them to a rock music score.

But in the end, that's the virtue of a free-market system: you get to see everything, form your own opinions, and bitch about what you see if you are so inclined. I am inclined to bitch. But all the same, and all things considered, I wouldn't have it any other way.

By Wayne Howell

NEWS

Money secrets revealed for US agents

WASHINGTON — A money laundering agreement with Britain and a Latin American law enforcement summit are part of the Reagan administration's international drive against drugs.

The agreement with Britain allows United States narcotics investigators access to the hitherto secret financial records in the Turks and Caicos, island smudges near the Bahamas which have been a haven for drug trafficking money. The Turks and Caicos are a British dependency.

Similar agreements for access to financial records have been made with the Cayman Islands, Italy, the Netherlands, and Turkey. Efforts are being made to extend this to other havens for drug money, especially Panama.

Attorney-General Edwin Meese arranged a meeting with US ambassadors in all countries where drug trafficking is a major problem. He also attended a law enforcement summit in Mexico City where the possibility of further joint action against trafficking, such as that recently completed in Bolivia, was discussed.

Bahamian Prime Minister Lynden Pindling is asking the US administration for up to a dozen helicopters, 10 planes, and 10 patrol boats to help in the fight against cocaine passing through the islands to the US.

In September, 1986, his government agreed to a program with the US which allows "hot pursuit" of suspected traffickers from the islands. The Bahamian police force is also being reorganized with the assistance of officials from Scotland Yard in London.

Teen anxiety, depression tied to potential drug use

WASHINGTON — Anxiety disorders and depression may precede the onset of drug abuse in 20% of adolescents and young adults, a study here conducted by the United States National Institute of Mental Health (NIMH) shows.

Prompt and effective treatment of mental illness could perhaps prevent their slide into drug abuse, the study adds.

The study of 18 to 30 year olds was part of a survey of mental disorders in Baltimore, Maryland; New Haven, Connecticut; St Louis, Missouri; Durham, North Carolina; and, Los Angeles, California.

James Burke and colleagues at NIMH, who presented their findings to the annual meeting of the American Public Health Association in Las Vegas, found there were earlier episodes of depression or anxiety disorders in 19% of drug abuse cases among young men and 22% among young women.

Dr Burke said, however, the figures do not prove mental illness can cause drug abuse. It could be that mental illness and drug abuse have a common origin and predisposition to both conditions.

Marijuana is the drug most often linked to earlier mental problems in both men and women. Cocaine abuse is more common in young women who were diagnosed earlier with anxiety disorders or depression.

The study did not define drug abuse as casual use: those defined as drug abusers had significant impairment in function for a month or more.

The most common signs of depression in the young people included a drop in school performance, problems in getting along with others, a drop in appetite, insomnia, inability to concentrate, and, at times, feelings of despair.

No smoking preferred in NS hospitals

HALIFAX — A firm policy discouraging smoking in virtually all areas of Nova Scotia's hospitals and other health care institutions has been prepared by the province's health minister.

But, Health Minister Ronald Russell will stop short of actually legislating a ban as urged in a petition collected by the provincial medical society and signed by about 45,000 people.

That petition was presented to Mr Russell here, following an address to the medical society annual meeting.

More than half the doctors in the province participated in circulating the petition, said Mark Kazimirski, MD, chairman of the society's committee on smoking and health.

Mr Russell told the meeting a lengthy policy concerning hospital smoking had been prepared by his ministry. The policy had not yet been sent out to hospital administrators because approval by the government's policy board is needed.

Later, Mr Russell said, "I don't intend to dictate to hospitals that they adopt this policy. But, I'm going to strongly recommend to them they do so."

The policy would restrict smoking in hospitals to designated areas, the private rooms of patients who wish to smoke, or wards in which all patients agree to permit smoking.

REVIEWS

New Books by MARGY CHAN

Addiction Prone: Evaluation of the General Substance Abuse Model by Comparing Correlates of Abuse of Four Common Substances

. . . by Kathryn Graham, Ardith Ekdahl

This working paper from the Addiction Research Foundation in Ontario is a review of the correlates of four commonly used substances of abuse: alcohol, tobacco, food, and caffeine. The general substance abuse model is evaluated by reviewing previous research on the four different substances. The approach is integrative, comparing all substances within a single framework, and multivariate, employing a variable level analysis from many areas of research. It is also evaluative, using a rating system to justify the conclusions for each variable.

The addiction field is still a long way from being able to predict who is addiction prone. This review provides drug abuse researchers with a broad basis, however, for further studies.

Addiction Research Foundation, Toronto, Ontario. 135 p. $8.50. ISBN 0-88868-138-0.

Alcohol and Culture: Comparative Perspectives from Europe and America

. . . edited by Thomas F. Babor

This book is the result of the 1983 conference, Alcohol and culture: comparative perspectives from Europe and America, sponsored by the United States National Institute on Alcohol Abuse and Alcoholism, the World Health Organization, the International Council on Alcohol and Addictions, and the Connecticut Alcohol and Drug Abuse Commission.

Sections are included on social epidemiology of alcohol problems, ethnic and national differences in the manifestation and meaning of alcoholism, socialization and acculturation in the etiology of alcoholism, alcoholism treatment in a cross-cultural perspective, and implications for research and prevention policy.

Annals of the New York Academy of Sciences. Vol 472, July 11, 1986. New York Academy of Sciences, New York, NY.

Perspectives on Drug Use in the United States

. . . edited by Bernard Segal

This monograph is also volume 1, number 1 of a new journal, *Drugs and Society*. The journal is intended to provide a contrast to the traditional journal format and content, concentrating on review of contemporary issues in the field of drug abuse and presenting new ideas with direct implications for practice and research.

In the first issue, several important issues on drug use in the United States are addressed: drug laws and drug law enforcement, the deviance model of drug-taking behavior, and women: alcohol and other drugs.

Haworth Press, New York, NY. 1986. 126 p. $24.95. ISBN 0-86656-586-8.

Other books

Psychopathology and Addictive Disorders — edited by Roger E. Meyer, 1986. This book includes articles by leading investigators in the addiction field. Topics are: understanding the relationship between psychopathology and addictive disorders, varieties of psychopathology found in patients with addictive disorders, family history of psychopathology in alcoholics, family pedigree of psychopathology in substance abusers, childhood behavior problems and adult antisocial personaltity disorder in alcoholism, "psychiatric severity" as a predictor of outcome of drug abuse treatments, psychiatric disorders in opiate addicts, psychotherapy as an adjunct to methadone treatment, relevance of laboratory studies in animals and humans to an understanding of the relationship between addictive disorders and psychopathology, alcohol idiosyncratic intoxication and other alcohol-related states of acute behavioral disinhibition, neurophysiological and neuropsychological concomitants of brain dysfunction in alcoholics, alcoholism and depression, treatment implications of a psychodynamic understanding of opioid addicts, and psychopathology produced by alcoholism. Guilford Press, New York. 362 p. ISBN 0-89862-680-3.

Preparing Your Church for Ministry to Alcoholics and Their Families — Thomas Hamilton Cairns, 1986. This book is a manual for local church personnel, both lay and clerical. It covers three basic topics: why churches should be involved in ministry to alcoholic families, what ministry churches can provide, and how churches can equip themselves for such ministry. Charles C. Thomas, Springfield, Illinois. 123 p. ISBN 0-398-05230-1.

Healthy Choices — Sharon Gibb, 1985. A drug education program aimed at 10 to 12 year olds is outlined. The three-book series, which also includes *Using Drugs Safely* and *Smoking and Drinking*, provides teachers with the resources needed to plan, prepare, and deliver a comprehensive and lively unit of instruction. Doubleday Canada, Toronto.

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FILM REVIEWS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Maybe I Am: The Story of a Teenage Alcoholic

Number: 759.
Subject heading: Youth and alcohol.
Details: Two-part filmstrip on videotape.
Synopsis: Kurt is having trouble at home, at school, and with his girlfriend. From drinking to overcome shyness, he now drinks to get drunk. Drinking is becoming the most important aspect of his life; he is late for school or absent and is beginning to have blackouts. One day, the coach catches him drinking and takes him to a counsellor. For a while, nothing changes. Then, his mother stops covering up for him, and his girlfriend learns different ways to deal with him. Kurt is finally convinced to go to a young people's Alcoholics Anonymous meeting. At first he refuses to listen, but, perhaps, next time he will be more receptive.
General evaluation: Good to very good (4.5). This video realistically portrays the problems friends, family, and school personnel have when confronted with a young problem drinker. However, there is concern the video overemphasizes the disease concept of alcoholism.
Recommended use: With a resource person, the video could assist teachers, guidance counsellors, and parents in identifying teenage alcohol problems. It could also be useful for young people 12 to 18 years of age.

The Subject of a Moment

Number: 767.
Subject Heading: Impaired driving.
Time: 30 min.
Synopsis: Wes works part-time in a service station. One weekend, the boss's family goes away. Wes goes to a party where many of the young people are intoxicated. Wes refuses a beer since he's already had a couple and his reason for coming to the party is to look for Roxanne. He sees her go off with someone else and leaves the party. On the way home, lights from a tailgating car interfere with his driving; Wes hits an oncoming car. He is taken to jail, photographed, and fingerprinted. The victims are his boss's family. Wes maintains it was an accident; his lawyer says he will be tried in adult court for automobile homocide, with conviction probable. Wes's school friends shun him. And, as he goes to court, his boss confronts him, asking if his child would be alive if Wes had not had those few beers.
General evaluation: Fair (3.4). This film presents many issues relating to impaired driving. However, the pace is slow, and the film is confusing in parts. General broadcast is recommended.
Recommended use: With a resource person, the film could be used with those 15 to 18 years old.

The Smoking Habit: How to Quit

Number: 751.
Subject heading: Smoking.
Details: Two, 14-min filmstrips with audio cassettes.
Synopsis: Part one, using statistics from the 1964 United States Surgeon General's Report, outlines the many hazards of smoking; despite warnings on cigarette packages and a ban on cigarette advertising on television, many young people continue to take up smoking. Part two looks at ways to kick the habit; several methods are recommended.
General evaluation: Very poor to poor (1.6). The filmstrips are out-of-date, with information that is no longer accurate.
Recommended use: The filmstrips should no longer be shown.

Powers and Becoming

Number: 769.
Subject Heading: Attitudes and values; lifestyle.
Details: Three video tapes, approximately 20 min each.
Synopsis: Ken Lowe illustrates universal activities — for example, conversation, listening, people watching (**The Journ**al, January) — people can engage in almost anywhere with practically no equipment. Each activity can change the way we feel and make life better. However, activities like intoxication can cause problems. We must develop our powers and learn to be capable. Our environment has a strong impact. We need to be challenged and must learn that making mistakes is not failure.
General evaluation: Very good to excellent (5.6). These videos are well-produced and contain many ideas that can lead to good discussion about lifestyle and the place of intoxicants in one's life. General broadcast is recommended.
Recommended use: With resource people, the videos could benefit all audiences over 11 years of age.

Drunk and Disorderly

Number: 765.
Subject Heading: Alcohol/alcoholism; women and alcohol.
Time: 30 min.
Synopsis: Liz, a 23-year-old British woman, is in jail for the third time as drunk and disorderly. Whenever she drinks, she becomes loud and aggressive. Her parents recall she was always having accidents, but they never related them to her drinking. Liz attempted suicide several times. Her probation officer suggests her release from jail will offer her last chance for recovery. Liz does not remain abstinent and is jailed again; she is sent to a long-term treatment centre, she feels there is little hope of recovery.
General evaluation: Fair to good (3.9). This documentary is well-produced, but its British context makes it difficult to relate to for North American audiences.
Recommended use: The film could be used with health professionals.

Earnie Larsen: Relationships

Number: 766.
Subject Heading: Treatment/rehabilitation.
Time: 30 min.
Synopsis: Earnie Larsen lectures on the value of relationships in recovery. It is important that the chemically dependent person and significant others re-learn how to relate to each other; trust must be re-established. This is a skill that can be learned.
General evaluation: Poor (2.3). The lecturer has some good information, but the format is boring.
Recommended use: The film could be used with family members in treatment.

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Alcohol Advertising: Public Forum — Feb 17, Toronto, Ontario. Information: Special events, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Hospitals Meeting the Challenge of Alcohol and Drug Problems — March 5, Toronto, Ontario. Information: Gwen MacKinnon, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Relaxation and Stress Management Workshop — March 5-6, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

The Community and Northern Justice — March 15-20, Whitehorse, Yukon. Information: Northern conference office, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Suicidal Behavior in Children — March 20, Windsor, Ontario. Information: Antoon A. Leenaars, suicide prevention/awareness committee, Dept of Psychology, University of Windsor, 401 Sunset Ave, Windsor, ON N9B 3P4.

Seminar for Scientists — April 2, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Behavioral Interventions Course — April 6-8, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Addictions Foundation Atlantic Conference 87 — April 26-30, Saint John, New Brunswick. Information: Roger A. Alain, information officer, Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, NB E3B 5H1.

1st Pacific Institute on Addictions — May 5-8, Langley, British Columbia. Information: Karl Burden, Alcohol and Drug Concerns Inc, 11 Progress Ave, Ste 200, Scarborough, Ontario M1P 4S7.

29th Annual Assembly of the College of Family Physicians of Canada — May 10-13, Halifax, Nova Scotia. Information: College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario M2K 2R9.

PRIDE Canada 3rd National Conference on Youth and Drugs — May 14-16, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

87th Annual Conference of the Canadian Lung Association — May 29-31, Montreal, Quebec. Information: Les McDonald, director, Health Education and Program Services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

Canadian Multidisciplinary Road Safety Conference and Annual Meeting of Canadian Association of Road Safety Professionals (CARSP) — June 1-3, Calgary, Alberta. Information: Madeleine Aldridge, conference coordinator, Faculty of Continuing Education, University of Calgary, 2500 University DR NW, Calgary, AB T2N 1N4.

Work and Well-being 87 — June 12-14, Edmonton, Alberta. Information: Canadian Mental Health Association, #200, 12120 - 106 Ave, Edmonton, AB T5N 0Z2.

Summer School for Addiction Studies — July 6-24, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1

28th Annual Institute on Addiction Studies — July 12-17, Hamilton, Ontario. Information: Betty Collins, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

United States

Current Developments in Adolescent Treatment: Reasons for Hope — Feb 28, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

3rd National Convention on Children of Alcoholics — Feb 28-March 5, Orlando, Florida. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, FL 33069.

International Native American Solvent Abuse Conference — March 2-4, Tulsa, Oklahoma. Information: Travis Jackson, president, Native American Research and Technical Assistance Center, Inc, 411 E St, Seminole, OK 74868.

10th Annual Alcohol Symposium, Diagnosis and Treatment: New Perspectives on Old Dilemmas — March 7, Boston, Massachusetts. Information: Judy Reiner Platt, Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139.

12th Annual Regional Institute on Alcohol and Drug Abuse — March 10-11, Belton, Texas. Information: Central Texas Council on Alcoholism and Drug Abuse, PO Box 203, Temple, TX 76503.

PRIDE 1987 International Conference on Drugs — March 19-21, Atlanta, Georgia. Information: Jean Alford, National Parents' Resource Institute for Drug Education, Inc, 100 Edgewood Dr, Ste 1216, Atlanta, GA.

5th National Symposium on the Impaired Nurse — March 25-27, Atlanta, Georgia. Information: National Nurses Society on Addictions, 2506 Gross Point Rd, Evanston, Illinois 60201.

American Society for Clinical Pharmacology and Therapeutics Annual Meeting — March 25-28, Orlando, Florida. Information: Elaine Galasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

American Orthopsychiatric Association Annual Meeting — March 25-29, Washington, DC. Information: Marion Langer, executive director, 19 W 44th St, Ste 1616, New York, NY 10036.

Chemical Dependency and Eating Disorders: Common Denominators and Differences — March 28, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

Western Conference on Addiction — April 2-4, Salt Lake City, Utah. Information: Charter Medical Corporation, addictive disease division, 11050 Crabapple, Rd, D-120, Roswell, Georgia 30075.

Southwest Conference on Wellness — April 23-25, Tempe, Arizona. Information: Diane C. Fausel, conference coordinator, Community Resource Associates, 8338 E Buena Terra Way, Scottsdale, AZ 85253.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism: Alcohol and Sports — April 23-26, Cleveland, Ohio. Information: Forum coordinator, NCA, 12 W 21st St, New York, NY 10010.

Biological Advances in the Treatment of Chemical Dependency — April 25, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

Northeastern Conference on Alcohol and Drug Dependence — May 3-6, Newport, Rhode Island. Information: Jane A. Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Road, Newport, RI 02840.

American Psychiatric Association Annual Meeting: Psychiatry in Medicine; Medicine in Psychiatry — May 9-14, Chicago, Illinois. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

American Society of Hospital Pharmacists Annual Meeting — May 31-June 4, Washington, DC; Clinical meeting, Dec 6-10, Atlanta. Georgia. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

4th Annual Summer Institute for Alcohol and Drug Studies — June 1-5, Evansville, Indiana. Information: Nadine Coudret, director, Institute for Alcohol and Drug Studies, University of Evansville, 1800 Lincoln Ave, Evansville, IN 47722.

3rd Annual National Rural Institute on Alcohol and Drug Abuse — June 7-11, Eau Claire, Wisconsin. Information: National Rural Institute on Alcohol and Drug Abuse, Arts and Sciences Outreach, University of Wisconsin, Eau Claire, WI 54702-4004.

National Clergy Council on Alcoholism and Related Drug Problems Annual Meeting — June 15-19, St Augustine, Florida. Information. John O'Neill, executive director, 1200 Varnum St NE, Washington, DC 20017.

Abroad

Symposium on the Prevention of Alcohol Misuse Among Children and Young People — Feb 25-26, London, England. Information: Institute of Alcohol Studies, Alliance House, 12 Claxton St, London, SW1H 0QS.

The International Congress for Alcoholism and Drug Abuse Counselors — March 13-21, London, England. Information: Tom Claunch, PO Box 210638, Montgomery, Alabama 36121.

7th International Conference on Alcohol Problems — April 5-10, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

International Symposium: Medical Education and Alcoholism — April 20-23, Santiago, Chile. Information: Alfredo Pemjean, Universidad de Chile, Facultad de Medicina, División Ciencias Médicas sur Proyecto: Educación Médica y Alcoholismo Correo 10-D, San Miguel, Santiago, Chile.

3rd Annual International Industrial Alcoholism Symposium — May 25-27, Frankfurt, West Germany. Information: Sara Bilik, symposium chairperson, Conecta Partners, Berger Strasse 211, 6000 Frankfurt 60 FRG, West Germany.

16th International Institute on the Prevention and Treatment of Drug Dependence and the 33rd International Institute on the Prevention and Treatment of Alcoholism — May 31-June 5, Lausanne, Switzerland. Information: International Council on Alcohol and Addictions, Case postale 189, 1001 Lausanne, Switzerland.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

International Conference on Alcohol-related Problems at the Workplace — Sept 27-Oct 1, Newcastle-upon-Tyne, Great Britain. Information: Peter Rørstad, director, North-East Council on Addictions, 1, Moseley St, Newcastle-upon-Tyne, NE1 1YE, Great Britain.

At least, at last, we admit to alcohol problems

Ireland now grasping a thorny issue

DUBLIN — The Irish National Council on Alcoholism (INCA) wants tougher laws on alcohol sales and price increases to counteract the drug's abuse.

Mr Justice Declan Costello, INCA chairman, told delegates at a recent conference here that Irish people spend 12% of their disposable income on alcohol, an international record. Alcohol consumption in Ireland has risen dramatically — by 113% between 1950 and 1979 — among those older than 15 years.

Citing the need for urgent action, Mr Justice Costello said price increases, coupled with better enforcement of tougher laws, could lead to a reduction in consumption.

"Existing legislation designed to restrict teenage drinking is defective and requires amendment," he said.

The INCA suggests it should be an offence to allow a young person under the age of 18 years to be on licensed premises, not, as now, those aged 15 years and under. It also suggests pub owners should no longer have the legal excuse they didn't know the person was underage when buying drink.

The Council also wants the law changed so that both the underage drinker and the publican are liable to charges.

Correspondent Karen Birchard *reports on alcohol abuse among the Irish.*

Village pub: often the centre of Irish community life

— Maplines

Attitudes to alcohol are liberal and tolerant in Ireland, where the pub is often the centre of community life. The president of Ireland, Dr Patrick Hillery, observes there could be few people in the country to whom the unhappy results of alcohol abuse are not all too visible: "Yet because of a misguided toleration of what we euphemistically call a 'weakness' in people, a most pressing problem is permitted to gather momentum.

"It is no small achievement to be able to claim that now at least, at last, we admit there is a problem," he told the conference here.

The Irish National Council on Alcoholism (INCA) points out that with the sharp increase in consumption, there has been a consequent rise in both health and social problems. It dismisses those who suggest the link between consumption and alcohol abuse has not yet been proven, saying they accept as valid the recent report by the British Department of Health linking the sharp increase in alcohol misuse in the United Kingdom with the overall rise in consumption there.

Ireland is a small country with a population of under four million people, more than half of them under the age of 25 years. Statistics on Irish drinking are inadequate, but the conference was told there are an estimated one and a half million Irish drinkers. The Irish Medico-Social Research Board calculates that, at current rates, one in every eight men and one in every 40 women will have been admitted to hospital at least once for alcoholism treatment.

Minister for Health Barry Desmond spoke of the Irish attitude to drink and the need to change the situation. "We have a poor regard for the man who cannot hold his drink and accept the man who can. However, when he cannot control his drinking and we consider him a nuisance, we have tended to hive off the problem drinker to the psychiatric services where he acquires an additional label."

Mr Desmond points out approximately 25% of the annual admissions to psychiatric hospitals are due to alcohol-related problems. It is also estimated the cost of alcohol-related problems now approaches SIR 600 million (Cdn $1.14 billion) annually, including health and social services costs plus lost production and lost taxes.

Mr Desmond, along with several other speakers, hit out at the slickness of advertising and its effect on young drinkers. Recent statements by Canadian Minister of National Health and Welfare Jake Epp were quoted: "I am concerned that the lifestyle content of such advertising encourages our young people to begin drinking at earlier ages. I believe advertising at rock shows and the use of celebrities is simply inappropriate."

Donal O'Shea, chairman of the Irish Health Education Bureau, said in Ireland Mr Epp could have added local festivals, national music festivals, and major sporting events, all of which deliver to young people the message that alcohol is synonymous with entertainment and enjoyment.

Mr O'Shea said it is now essential for the Irish public to be more effectively alerted to the major health hazard alcohol poses and to the risks and harm associated with it.

"It is also essential that public debate be stimulated on the possible remedies," he said, quoting recent research that the public regards alcohol as a serious problem, but as a less serious one than muggings or other drug abuse.

Mr O'Shea said there is statistical evidence linking alcohol sales to prices, but little research has been done to establish how various groups within the population react to price movements.

"The figures for alcohol addiction indicate it is lower-paid workers who most need treatment and higher-income groups have the lowest levels of addiction. It could well be that when prices rise, moderate drinkers drink less but heavy drinkers don't change their consumption."

An effective national policy must take into account the political situation in Northern Ireland. Mr O'Shea also said the amount of alcohol imported or smuggled into the Republic from the north is also a difficult factor to measure.

Drink prices in the north are cheaper and, before the government removed some of the tax levied against alcohol, prices there were even cheaper.

Mr O'Shea: "We are familiar with the special excursions and trips which were organized to buy drink there and of people who seldom purchased alcohol who felt compelled by the 'bargain' to load up the car during a visit to the north."

Norman Kreitman, director of the Unit for Epidemiological Studies in Psychiatry, Royal Edinburgh Hospital, where research into the public health aspects of alcohol-related harm is underway, outlined five principle strategies for containing the extent of alcohol-related damage:

- **public health approach** concerned with the overall relationship between consumption and harm. Of the factors which influence consumption, price is the most important, but questions of availability and advertising need to be considered. Government intervention is essential for a coherent policy to be implemented;
- **education**, for both children and adults, which so far has been of very uncertain efficacy;
- **early detection and screening**, mounted through primary care agents, probation agents, etc, and in the workplace;
- **early intervention**, by all treatment agencies. Punitive intervention by the police with drunk drivers, for example, can also be considered under this heading: and,
- **treatment of problem drinkers**.

Dr Kreitman stressed the public health approach is probably the most important one in western societies.

The alcohol industry in Ireland is a major employer and taxes from alcohol contribute heavily to government coffers.

Harry Hannon, director of the Irish Brewers Association, said his industry is not an adversary in the fight against alcohol misuse.

"We are, as an industry, equally concerned at the toll it takes on society and support the need for positive measures to prevent abuse.

"Research and experience throughout the world testify that the most effective way to deal with alcohol abuse is through prevention, educational programs at a young age, peer group influence, and parental example.

"The problem of abuse is a people problem, not a product problem."

The Irish Brewers Association has embarked on comprehensive measures to help in the fight against alcohol abuse, including workplace programs, policing a strict advertising code, and supporting campaigns against drunk driving.

In Mr Hannon's view, a national alcohol policy "must be realistic, take account of the positive role alcohol plays in society, and deal with the problem of abuse in a constructive and positive way."

Secretary of the Irish Department of Health Liam Flanagan says government policy is now directed toward implementing recent recommended changes to Ireland's health care system.

Mr Flanagan said the preventive approach to alcohol problems is being stressed and there is a need to train more alcoholism counsellors so that local treatment centres can be set up with outpatient facilities.

"What is needed in a treatment model is a partnership between therapist and client, in which the client gradually takes over responsibility for control of his drinking. This does not require an institutional setting."

He stressed the importance of the general practitioner's role in preventing alcohol abuse. "While people with evident signs of alcohol abuse are easily diagnosed, it takes great skill to spot the alcohol abuser a decade earlier."

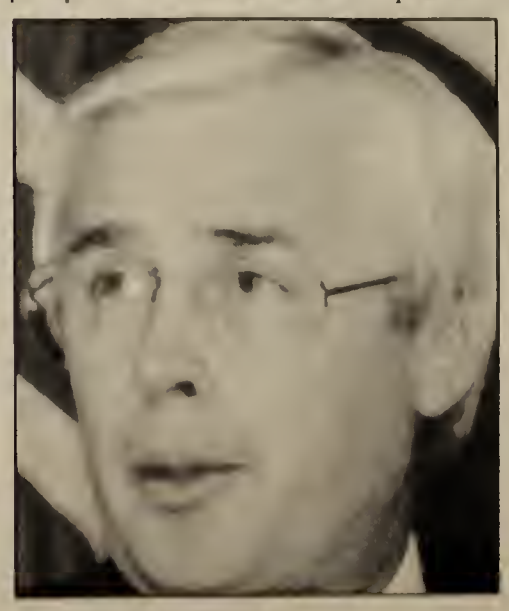
Mr Flanagan points out the irony that now exists in Ireland with the general public viewing alcoholism as a disease at a time when professionals tend to see problem drinking as a socially learned behavioral disorder.

The alcohol issue has a number of characteristics that make it particularly thorny to deal with in Ireland. Like tobacco, alcohol poses something of an economic paradox, providing jobs and revenue to the government while imposing significant costs in terms of health care, suffering, and lost production.

Also, there is a degree of ambivalence in attitudes to alcohol. There is recognition of the alcohol problem, but Irish drinking habits suggest a tolerance of excessive drinking which is reflected by the central position alcohol occupies both in day-to-day activities and festive occasions.

Festivals are celebrated throughout Ireland, and there is usually sponsorship from drink-related industries. For example, big music weekends are heavily supported by various breweries. A festival, even a small village one, is always accompanied by an extension of the licensed drinking hours.

Concludes Mr Flanagan, the current economic and cultural situation in Ireland militate against any simplistic solution to alcohol abuse here.



Epp: ads inappropriate

Hillery: gathering momentum

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The Journal

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Decisions can be made, says Oppenheimer

UN global conference on drugs 'vital step'

Anne MacLennan reports

VIENNA — Some 2,500 people from countries around the world, including Canada, are expected to attend the United Nations global, ministerial-level conference on drugs here from June 17 to 26.

The ICDAIT — International Conference on Drug Abuse and Illicit Trafficking — is "the least-funded conference" in UN history, says Tamar Oppenheimer, now secretary-general of the conference and director of the UN Division of Narcotic Drugs here from 1982 to 1986.

She told a press conference about a half million dollars is available from the UN to operate the conference; typically, participating countries and organizations will contribute their own costs. On a world scale, these costs will be remarkably high, given the expense of advance work and travel and the numbers of delegates who will be attending the 10-day meeting.

However, opening the first and final preparatory meeting here for the conference, Mrs Oppenheimer said because participants are expected to be "cabinet level," the event should provide "a unique opportunity for decision-making."

It will "represent a vital step toward mobilizing society in bringing together the various elements and components of the needed counter-offenses," she said.

Unlike other UN conferences, on the environment, for example, there is consensus the June meeting is not a consciousness-raising event.

"Everybody is very aware this

Oppenheimer: mobilize society

conference is specifically designed to help individuals, organizations, and governments work together to develop methodologies and ways to combat drug abuse and illicit traffic in drugs," said Mrs Oppenheimer.

The ICDAIT meeting — and the call for high-level political commitment by the UN Secretary-General that brought the conference about (**The Journal**, July, 1985) — is one catalyst for the national strategy on drugs currently being developed by the Canadian government (**The Journal**, December, 1986).

That strategy is expected to be announced in Canada by Health Minister Jake Epp soon — and before the fact of its existence is signalled to the international community at the ICDAIT in June.

Much hope for the success of the ICDAIT conference has been vested in a working manual on activities to combat drug abuse drafted over the last year and with comments from governments and intergovernmental and non-governmental organizations.

The *Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control* — or the CMO, as it's called — has been the centrepiece of planning for the conference — by the UN Commission on Narcotic Drugs (and the preparatory body) in its two meet-

(See Politics, p2)

LeCavalier: no change needed

Soviets query heroin use

By Anne MacLennan

VIENNA — Sixteen months after it made heroin available in hospitals for treatment of chronic pain for the terminally ill, Canada argued the case again, briefly, at the United Nations Commission on Narcotic Drugs here.

Generally, the Commission was focusing on the more current, pressing problem of cocaine production and abuse and continued expansion of illicit trafficking.

But, the Union of Soviet Socialist Republics re-opened debate and sponsored a resolution to ban all heroin use, for any purpose, internationally.

For Canada, Jacques LeCavalier noted the current international law allows for heroin's medical use, where a country deems it appropriate and not dangerous to public health, and there is no reason for that to change.

It has not changed.

Later, Mr LeCavalier, who is director of Canada's Bureau of Dangerous Drugs, told **The Journal** that about four kilograms of licit heroin were sold in Canada last year — which represented both company and hospital stocks and re-stocks, as well as treatment supplies. (It has been available since December, 1985).

He said there has not been significant medical use of heroin to date in Canada. Nor do hospitals appear to be stocking the drug, although if a physician feels it may benefit a patient, the drug can be made available in 24 hours, even if the

(See Alternatives, p2)

Reagan faces fight on drug budget cuts

By Harvey McConnell

WASHINGTON — United States President Ronald Reagan's efforts, through the new federal budget, to emasculate the anti-drug bill passed before the November Congressional elections will be resisted here on Capitol Hill.

Many Democrats have made it known they will try to stymie efforts by the Republican administration to slash $913 million (Cdn $1,227 million) from education, prevention, and enforcement programs under an omnibus bill passed by the US Congress and signed by President Reagan.

The budget cutting is in sharp contrast to President Reagan's pledge in his January State of the Union message to continue to fight drugs and his declaration three months earlier when he signed the $1.4 billion bill and pledged "total commitment of the American people and their government to fight the evils of drugs."

However, experts here say that whatever budget cutters may wish to do, the drug issue is still a top concern among voters. This has been reinforced by a recent railway accident in this area in which 17 people were killed — two train engineers were found to have traces of marijuana in their blood — and the ousting of two players from the Houston Rockets professional basketball team for testing positive for cocaine.

(See Drug, p2)

ADAMHA chief replaces Turner

Macdonald to White House

WASHINGTON — Donald Ian Macdonald, MD, administrator of the United States Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) since 1984, has taken over as director of the White House Office on Drug Abuse Policy here.

Macdonald: assists Reagan

He will retain his ADAMHA appointment as well as being Special Assistant to the President for Drug Abuse Policy.

Dr Macdonald, a pediatrician, is an advocate of prevention and treatment programs for youth. He replaces Carlton Turner, PhD, who resigned from the White House post at the end of 1986 (**The Journal**, January) and who has since become head of a drug testing laboratory in New Jersey.

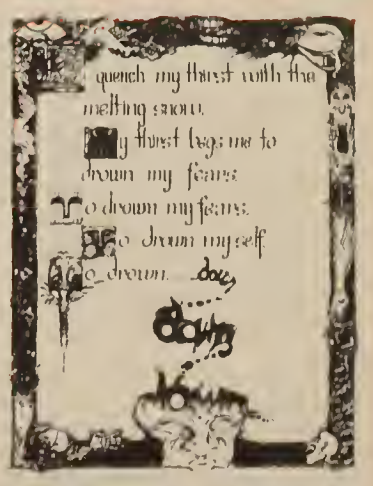
Meanwhile, Attorney-General Edwin Meese has announced all US government anti-drug efforts will be coordinated by one, cabinet-level board with control over prevention, education, treatment, and rehabilitation programs.

Until now, the National Drug Policies Board, set up in 1984, has only coordinated strategy for law enforcement efforts against trafficking.

Mr Meese said the board will set the budget priorities for every government agency involved in anti-drug efforts.

"This important step will provide policy coordination for enhanced government efforts to substantially cut the demand for drugs while maintaining and strengthening our long-range drive to reduce the supply of drugs," he said.

INSIDE



NEWS

Briefly . . .

Hidden tolls

LONDON — A British lobby group suggests nearly twice as many people in the United Kingdom are killed in drinking-driving accidents each year as government statistics indicate, *Doctor* reports. The Action on Alcohol Abuse group says statistics are not uniformly recorded in the UK, with more than 33% of coroners not making adequate return reports. It's more likely that 2,000 Britons die each year in such accidents than the 1,000 the government counts, says the group.

Biting the bullet

CHICAGO — The American Dental Association (ADA) in the United States has officially recognized chemical dependency as a disease, an association press release says. The ADA reports it is "committed to assisting the chemically-dependent member toward recovery," and that it "encourages institutions responsible for dental education to allocate adequate curriculum on substance use, misuse, and addiction."

Nyet to booze

MOSCOW — Soviet alcohol sales fell nearly 40% in the first 11 months of 1986, says a story in *The Globe and Mail.* Statistics, released by the Soviet Central Statistics Board, include figures on corresponding drops of 25% in the crime rate, 20% in road deaths, and 33% in absenteeism.

Brat packs

OTTAWA — The Toronto-based Non-Smokers Rights Association has taken the federal government here to task for allowing the tobacco industry to introduce "kiddie-packs" of 15 cigarettes nationally. The association fears the smaller packs will lead more teenagers to smoking, with more youngsters addicted to tobacco, says *The Globe and Mail.* The new packs make smoking more affordable for young people, suggests association executive director Garfield Mahood.

Drugs ahoy

LONDON — Charges of drug smuggling by sailors aboard British Royal Navy ships are now being investigated by the naval police. The Ministry of Defence here says the ships involved include the aircraft carrier Ark Royal. It is reported that some young sailors have been involved in smuggling hashish from Morocco and selling it in Portsmouth, a home base for most of the ships.

Rye humor

VANCOUVER — The British Columbia liquor control and licensing branch wasn't laughing at a magazine advertisement from Seagram Distillers Ltd, reports *The Toronto Star.* They banned the ad for Five Star rye showing a young businessman dejectedly looking on as three mechanics work on his car, because it associated driving and alcohol. The caption under the ad read, "If only everything was so smooth."

Second world conference set for 1988

Australia to target health promotion

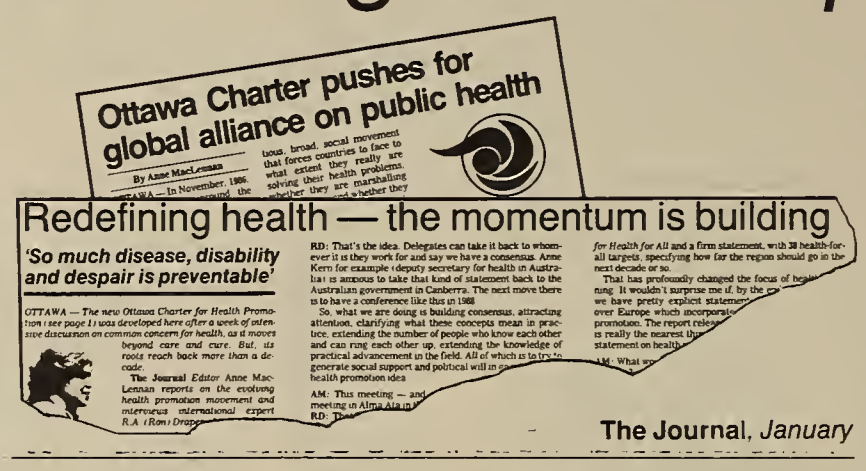
By Anne MacLennan

GENEVA — The second international conference on health promotion will be held in Australia in 1988.

The conference is a follow-up to the first, held in Ottawa in November, 1986 (**The Journal**, December, 1986).

The announcement was made by Bernie McKay, Australian secretary of health to the 79th session here of the executive board of the World Health Organization (WHO).

The Ottawa meeting culminated in the striking of the Ottawa Charter for Health Promotion, defined as, "the process of enabling people to increase control over, and to improve, their health."


Ottawa Charter pushes for global alliance on public health

By Anne MacLennan

...tious, broad, social movement that forces countries to face to what extent they really are solving their health problems. ...whether they are marshalling ...whether they

Redefining health — the momentum is building

'So much disease, disability and despair is preventable'

OTTAWA — The new Ottawa Charter for Health Promotion (see page 1) was developed here after a week of intensive discussion on common concern for health, as it moves beyond care and cure. But, its roots reach back more than a decade.

The Journal Editor Anne MacLennan reports on the evolving health promotion movement and interviews international expert R.A. (Ron) Drop...

RD: That's the idea. Delegates can take it back to whomever it is they work for and say we have a consensus. Anne Kerns for example (deputy secretary for health in Australia) is anxious to take that kind of statement back to the Australian government in Canberra. The next move there is to have a conference like this in 1988.

So, what we are doing is building consensus, attracting attention, clarifying what these concepts mean in practice, extending the number of people who know each other and can ring each other up, extending the knowledge of practical advancement in the field. All of which is to try to generate social support and political will in ... health promotion idea

AM: This meeting — and ... meeting in Alma Ata in ...

RD: ...

...for Health for All and a firm statement, with 38 health-for-all targets, specifying how far the region should go in the next decade or so.

That has profoundly changed the focus of health ...ning. It wouldn't surprise me if, by the ... we have pretty explicit statement... over Europe which incorporate... promotion. The report relea... is really the nearest th... statement on health...

AM: What w...

The Journal, *January*

The charter said: "The move toward a new public health is now evident worldwide," and called on individuals and countries to put health on the agenda of policy makers in all sectors and at all levels, to develop a socio-ecological approach to health, to strengthen community development, to support people's personal and social development, and to reorient health services beyond providing clinical and curative services.

Anne Kerns, deputy secretary for health in Australia, was one of the chief facilitators of the Ottawa meeting, by the end of which it was considered very likely Australia would host the next.

The Ottawa meeting was sponsored jointly by Health and Welfare Canada, the WHO, and the Canadian Association for Public Health.

The Australian meeting will coincide with the 40th anniversary of the WHO, the 10th anniversary of the Alma Ata Primary Health Care Declaration, and Australia's 200th birthday celebrations.

Alternatives make heroin phony issue

(from page 1)

hospital has no heroin in stock.

Mr LeCavalier said although the push to have it made available was often heated (**The Journal**, October, 1984), there is an array of drugs that are equally effective.

"The dramatization of the need for legal use was only equalled by those who didn't want it at all," he said.

He said individuals or governments who want to prohibit or ban heroin use on the basis that it is abused, or that there are better options available, should consider that the same arguments prevail for cocaine, methaqualone (eg, Tualone-300), and possibly other drugs.

"Certainly, there are alternatives to cocaine in medical practice, and no one will argue there isn't a significant amount of abuse. But, nobody talks about removing cocaine from medical use. The same applies to methaqualone.

"Heroin is a somewhat phony issue."

Mr LeCavalier confirmed that somehow ampoules being exported from the United Kingdom to Canada disappeared at Heathrow Airport in London last year and have still not been traced.

However, he said it was a small amount.

Scotland Yard and the RCMP (Royal Canadian Mounted Police) are investigating.

TJ writer honored as Woman of the Year


Hamilton Spectator

Lee: award winner

HAMILTON — Betty Lou Lee, medical writer with *The Hamilton Spectator* for more than 18 years and a regular correspondent to The Journal, has been named one of seven Women of the Year here.

Ms Lee, who has won the medical journalism award of the Canadian Science Writers Association, four western Ontario newspaper awards, and awards from the Canadian Health Care Public Relations Association, was named woman of the year in the communications category by the Hamilton Status of Women committee.

The communications category award is for "significant achievement within the broadest sense of communications."

Alcoholism can be mitigating factor in lawyers' misconduct, court rules

WASHINGTON — Alcoholism should be considered a mitigating factor in disciplining lawyers for legal misconduct, the District of Columbia Court of Appeals here has ruled.

In a precedent-setting decision, the court declared the District's disciplinary body should consider the claim of alcoholism when deciding on sanctions against lawyers.

"To fail to consider alcoholism as a mitigating factor would be to defy both scientific information and common sense," the court ruled.

The court, however, did not write any new rules. It left decisions to be made on a case-by-case basis as to whether the defense of alcoholism might affect a lawyer's conduct, noting, "Not all drinking alcoholics are unable to control their behavior."

The court, the final arbiter in disciplinary actions against lawyers in Washington, was acting on an appeal by a lawyer suspended for a year and placed on probation for four years for a number of violations, including three of misappropriating clients' money.

The court said the lawyer should instead be put on probation for five years, monitored, and continue treatment for alcoholism.

Politics encumbers UN drug debate

(from page 1)

ings, one in February, 1986, and the second this year.

The CMO was designed to enlist the participation of all segments of society at national, regional, and international levels, and to present a compendium of suggestions for practical activities for government agencies, professional associations, academic institutions, non-governmental organizations, parents and other individuals, and UN agencies and inter-governmental organizations.

It covers demand reduction, control of supply, action against illicit trafficking, and treatment and rehabilitation; and, it indicates specific targets for action.

Many participants in both the Commission on Narcotic Drugs and the preparatory body were privately concerned that the political commitments that the ICDAIT's success both called for and depends upon have only added to the cumbersomeness of the international debate on drugs, rather than to the debate itself.

They were concerned too that the CMO — an already ambitious document-by-world-committee — might share the same fate.

Drug tests demanded

(from page 1)

Several congressmen have moved swiftly to introduce bills for more random drug testing in the transportation industry, ranging from pilots and air traffic controllers to all employees involved in the operation of trains and planes.

Transportation Secretary Elizabeth Dole has called for testing for all personnel responsible for the safety of the travelling public, both in the public and private sectors. Testing would be carried out before employment, following any accident, or any situation with reasonable suspicion of drug use.

The two Houston Rocket players who tested positive for cocaine had not sought help under the anti-drug agreement between players and owners.

— coming up in —

THE JOURNAL

- PRIDE International conference
- US conference on alcohol, drugs, and women

NEWS

Only 27 of 873 cases linked to drugs

Canadian AIDS totals rise

By Elda Hauschildt

OTTAWA — Approximately 50,000 Canadians have been infected by the human immunodeficiency virus (HIV), and 873 people have developed AIDS, Health Minister Jake Epp told the House of Commons standing committee on national health and welfare here in February.

Of the 873 cases, 423 patients are still alive and 450 have died. The statistics show 816 of the cases involved men (with 411 deaths); 40 involved women (with 27 deaths); and, 17 involved children (with 12 deaths).

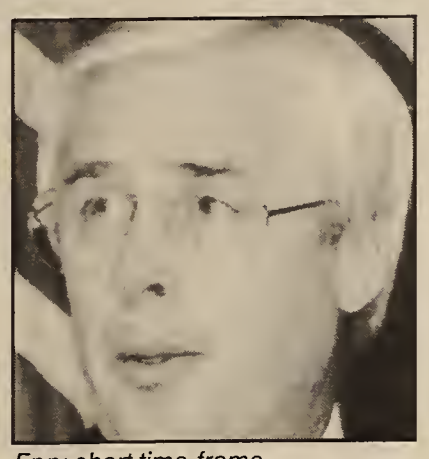
Gregory Smith, coordinator of the AIDS centre at the Laboratory Centre for Disease Control, Health and Welfare Canada here, told **The Journal** only three of the cases were related to intravenous (IV) drug use. But, he pointed out, 24 cases listed in the male, homosexual/bisexual category were known to be IV drug users as well.

Mr Smith said the data were correct as of February 9.

Mr Epp told the House committee that of the 50,000 Canadians infected with HIV, it is estimated 20% to 35% will develop AIDS.

"Those percentages are open to discussion because of the relatively short time-frame and the long incubation period of the disease," he said.

The minister also stated that of $39 million the federal government has budgeted for AIDS prevention, research, and treatment over the next five years, approximately $7 million will be for education.



Epp: short time-frame

Mr Epp told the House committee Canada's first national public health education campaign on AIDS is being launched by the Canadian Public Health Association (CPHA) this month (March). Financing from the federal government for the CPHA is $3.5 million over five years.

David Walters, MD, director of the AIDS education and awareness program of Health and Welfare Canada, told the standing committee the aim of the campaign is to inform Canadians of the preventive aspect of the disease.

"And that includes the sexual transmission of the disease, the transmission by shared needles in which blood is exchanged in the drug abuse situation, and some of the other mechanisms, those being the main ones at the present time extant in Canada."

Canada is organizing an international consultation on AIDS in mid-March with experts from the United States, the United Kingdom, Australia, the World Health Organization, and Canada.

— coming up in —
The Journal
- US national forum on AIDS and chemical dependency

Global statistics reflect only part of AIDS picture

GENEVA — Approximately 33,000 cases of AIDS have been reported to the World Health Organization (WHO) here, from 101 countries representing all continents.

The largest number of cases, 86% or 28,600 cases, are from the Americas, with Europe reporting 3,200 cases. Africa reported 1,000 cases. Oceania (all from Australia and New Zealand) 300, and Asia 55. The statistics were reported as of October, 1986.

The WHO states the official case list "reflects to a limited extent the actual scope of the current AIDS problem.

"Given the emotional and political climate which surrounds AIDS, we consider the reporting of even a fraction of known AIDS cases by national health authorities to express national willingness to deal constructively with the problem."

The WHO states that 91% of the reported cases — 26,000 — in the Americas are reported from the United States and that the US government estimates between one million and one-and-a-half million people there have been infected with the human immunodeficiency virus.

Cooking wine sales stir up controversy for Ontario retailers

By Peter Unwin

TORONTO — Major grocery store operators in Ontario have been asked to avoid selling cooking wines to minors.

The request, by Ontario Minister of Consumer and Commercial Relations Monte Kwinter, comes after recent publicity that minors are buying cooking wines and sherries for personal consumption.

A Toronto-area (Brampton) consumer group, AIM (Advise Inform Monitor), originally brought the issue to the attention of local media and politicians. "There is not enough care being taken in the distribution of this product," Joe Bartello, co-founder of the consumer group, told The Journal.

"Even cashiers admit there is absolutely no control (The Journal, February, 1986)."

Cooking wines range in price from two to three dollars per 750 millilitre bottle and have an alcohol content of up to 36%. They are not considered alcoholic beverages under the Liquor Licence Act because they contain sufficiently high quantities of salt to make them unpalatable.

The high salt level poses a health risk in itself, especially to people with high blood pressure or heart conditions.

Mr Kwinter, in his letter to Ontario store owners, stated his concern stemmed, "not only from the alcohol content, but also from the health risk posed by the salt levels if these products are consumed as beverages."

No changes in the liquor laws concerning cooking wines appear imminent. But, Mr Bartello says some grocery store owners have voluntarily pulled the products from their shelves following Mr Kwinter's request to exercise "extreme caution" to avoid sales to underage people.

Fake identification cards bedevilling US bartenders

WASHINGTON — Bar owners, bouncers, and liquor store owners in this area are reporting a sharp rise in fake identification (ID) use now that the legal drinking age is 21 years in the District of Columbia and surrounding Maryland and Virginia.

Some liquor store owners are so concerned about the problem that they've put up signs saying anyone under the age of 30 years will have to provide a valid ID, if asked.

Law enforcement officials say minors are very inventive at changing the dates of birth on ID or even superimposing pictures on legitimate identification.

INSIDE OUT

Smoking, and paying the piper

Oh, no, here I go, back in the clinic again.

It's a new kind of clinic, certainly; its purpose is not directly or obviously rehabilitative, and the concept is highly unstructured and still unsteady at the moment.

But I suspect it's soon going to be the wave of the future in hundreds, perhaps thousands, of office buildings in North America.

It's known as the 'smoking room' — although those who use it call it by many other, more vulgar names.

And, if the one I'm attending these days is anything like others already in use in other companies, these new clinics will be small, always cramped, airless, desolate spaces that sometimes, when the filter system isn't working well, make me think of nothing less than the holds of ancient slave ships.

The smoking room at my company is the result of an office-wide vote taken almost a year ago. More than half of my colleagues decided the time had come to stop smoking in the workplace altogether. Many people, including a surprising number of heavy smokers, concluded at the time of balloting that the cessation of smoking at desks was most certainly an idea whose time had come. So, when the final results were announced, there was, more or less, a sincere agreement that something positive had been accomplished.

But, that was before the time finally, inevitably, and cruelly arrived when the idea became terribly real.

That was when smokers who magnanimously had chosen to give non-smokers a break, felt giddily idealistic, full of integrity, and seduced by the notion that having a ban on cigarettes would nudge them closer to the day when they, too, would throw the damned things out, toss away the lighters and the matches, ceremoniously dump their ashtrays forever into the wastebasket, and walk out into the world at large as absolutely free men and women again, heads held high, the nicotine monkey removed, gloriously, from their backs.

Naturally, when Day One came, none of that happened at all. Instead, we smokers trooped into work feeling shaky, ill-tempered, full of rage, many of us also feeling bereft and mournful.

Cramped, airless, desolate spaces . . . that make me think of the holds of ancient slave ships

Some immediately lit up at their desks, not in defiance, but out of habit. They were quickly ordered to stop. We didn't know what to do with our hands all of a sudden. We could hardly make small talk. We were extremely self-conscious, like teenagers at the first dance of their lives.

But all of us, eventually, marched sheepishly to the smoking room before lunch, marched into the New Order of things, and began to realize the enormity of what had happened to us. We could feel the great ship of History begin to turn around. . . .

For those who had led the fight to ban smoking, it was a day of great triumph. They beamed, they crowed, they smirked endlessly, gathering together in small bands to celebrate the victory. We hated them; we still hate them now, but we have tried to maintain good cheer — some of us, anyway.

Quickly, the new subculture of the smoking room formed. Jokes were told, always about smoking. People talked about the loss of civil rights; some plotted a serious revenge on the do-gooders out there, in the big office.

That first week was heady. Novelty is always amusing, and many of us secretly believed the New Order would end: many of our bosses were heavy smokers, after all, and how long would they hold out? It was their building, after all.

The smoking room provided a chance to get to know people we'd never paid much attention to. New relationships were formed. Mailboys became pals with management types. Secretaries suddenly noticed certain male workers in a new and exciting light. There was a lot of shrill laughter. Office legends were beginning to unfold.

Yes, that first week, over all, could be construed now as fun, in a gallows-humor way.

But, by the end of the second week, the mood had shifted dramatically. Suddenly, people were not amused by their seemingly out-of-control compulsion to keep going back, again and again, to the smoking room. It became increasingly more difficult to stay with a work project until its conclusion without getting up to take that Long March across the huge office to have a smoke.

Those who didn't smoke were upset by the shift in the rhythm of work patterns; why were the 'sinners' getting more relaxation times than they, the stalwarts, the non-addicted ones trying to put in a good day's work?

We got tired of seeing the same old faces in the same old small room; we got tired of the predictable jokes. It is not fun to be around obsessive people, and smokers, when deprived of what used to be the normal order of things, are strikingly obsessive.

I have been in a rehabilitation clinic for alcoholism, and this was a reminder of nothing more than some of the group therapy sessions I used to be in. We smokers talked, by Week Three, of going to hypnotists. Acupuncturists became chic. Stop-smoking programs were discussed with fervor. We were finally beginning to face just how addicted we truly were to this insidiously seductive habit.

We were beginning to feel like children being sent constantly into the corner of the classroom by a very disapproving teacher. The notion this was how it would be, for years and years to come — this incessant strolling to the smoking room — was becoming unbearable. It was becoming ludicrous; people were bringing their work into the smoking room, which was rapidly taking on the form of an opium den.

People who had thought of themselves as functioning adults, responsible types, were forced to look again at the damaging evidence that was being pushed in front of their faces every day.

We were hooked, all right, and in a big way. We simply couldn't control ourselves. We just couldn't stop this overwhelming urge. Pavlov smiled somewhere, we were sure.

And now, for many of us, the smoking room has become almost like one of Dante's circles of hell.

How do we get the hell out of here?

That's what we all want to know.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

UK deaths attributed to sniffing

Deaths caused by the abuse of volatile substances in the United Kingdom have continued to rise in the past five years. An initial survey reported 282 deaths from such abuse between 1971 and 1983, and follow-up by researchers at St George's Hospital Medical School, London, indicates 385 such deaths occurred between 1981 and 1985. A number of methods, including press clippings and inquest proceedings, were used to track the UK deaths attributed to abuse of volatile substances. The annual number increased to 116 in 1985, from 46 in 1981. More than half were related to direct toxic effects of the substance, with the remainder thought to be due to intoxicated behavior or asphyxiation. Deaths from abuse of fuels, aerosol sprays, and solvents in glue were recorded in each of the five years. The researchers, headed by H. R. Anderson, MD, head of the department of clinical epidemiology and social medicine, conclude abuse of volatile substances is more than a passing fashion and that various preventive efforts have not been successful.

British Medical Journal, December 6, 1986, v.293:1472-1473.

Ts and blues problem revisited

Evidence shows that Talwin Nx has not solved the drug abuse problem associated with 'Ts and blues.' The combination of oral formulations of pentazocine hydrochloride (eg, Talwin) and tripelennamine hydrochloride (eg, Benzoxal) has been known to be abused as an intravenous heroin substitute since 1977. In response, Talwin Nx, combining pentazocine hydrochloride with a narcotic antagonist naloxone in the hopes of blocking the effect of the pentazocine if the drug was injected, was introduced in 1983. But, two physicians from the departments of psychiatry and behavioral sciences and pharmacology at Northwestern University Medical School, Chicago, Illinois, have produced the first published report of two cases of abuse of the new formulation in combination with tripelennamine. One patient reported he knew at least seven other people injecting the new combination. Drs Deborah Reed and Sidney Schnoll give several possible reasons for the failure of the naloxone in Talwin Nx to block the effect of the pentazocine, the most likely being that the drugs are acting on different opiate receptor sub-types and that tripelennamine alone may possess mood-enhancing effects. They also speculate the dose of naloxone hydrochloride might be insufficient to block the combined effects of pentazocine and tripelennamine. They conclude that while there has been a marked decrease in the number of patients reporting abuse of Ts and blues, this reduction could not be attributed to the introduction of Talwin Nx and is more closely associated with an increase in the availability of low-priced heroin.

The Journal of the American Medical Association, November 14, 1986, v.256:2562-2564.

Head injuries missed in alcoholic patients

Alcoholics with serious neurologic deficits should be watched for traumatic head injuries, say two Scandinavian researchers. They found traumatic brain injuries can easily be missed in this patient population. Matti Hillbom from the Clinical Alcohol and Drug Research Department in Karolinska Hospital, Stockholm, Sweden, and Lena Holm from the Department of Neurology at the University of Helsinki, Finland, interviewed 157 recently detoxified alcoholics and an age-matched control group of 400 subjects from the same geographic area. They found 41% of the male alcoholics and 22% of the females had suffered head injuries in the past, compared to 15% and 6% respectively of the males and females in the control group. About one-third of the cases in each group had been admitted to hospital for treatment of these head injuries. The alcoholics who reported traumatic head injuries not identified at hospital performed worse in neuropsychological tests and showed more profound brain atrophy than the alcoholics who denied having ever suffered a head injury. The researchers conclude that unrecognized traumatic brain injuries can contribute to intellectual impairment of alcoholics and that a considerable number of such injuries go unrecognized.

Journal of Neurology, Neurosurgery, and Psychiatry, December, 1986, v.49:1348-1353.

Asking the right questions

A simple questionnaire can successfully identify adolescents at risk of alcohol and other drug abuse, say a group of researchers in the eastern United States. The 42-item questionnaire asks groups of questions about self-reported substance abuse, use patterns by relatives and close friends, and items related to risk factors for abuse identified in the literature or through the clinical experience of the researchers. To test the efficacy of the questionnaire, two different groups of adolescents were polled: 206 youths between 14 and 17 years old seen in a private medical practice in Washington, DC, in a three-month period in 1985, and 97 demographically similar youths from a drug and alcohol abuse treatment program in the same city. The researchers from the Pacific Institute of Research and Evaluation in Bethesda, Maryland, and George Washington University in Washington found the questionnaire was successful in discriminating between the two groups and also in discriminating drug and alcohol risk within the samples. The study concludes: "A simple, paper-and-pencil questionnaire can successfully discriminate the degree of risk of substance abuse in adolescent patient populations, and . . . such an instrument can be successfully integrated into the routine activities of pediatric practice."

American Journal of Diseases of Children, January, 1987, v.141:45-49.

Pat Rich

No-smoking bylaw clear hit with Winnipeg businesses

By Maureen Brosnahan

WINNIPEG — An overwhelming number of business operators and restaurant owners here support the city's no-smoking bylaw, a major survey by the Manitoba Interagency Council on Smoking and Health indicates.

The survey, conducted last summer, shows more than 87% of 650 businesses surveyed were aware of the bylaw. Of 160 restaurants, 93% complied with the law calling for a no-smoking section in places that seat more than 30 patrons. In many cases, restaurants had significantly increased the size of their no-smoking sections since the bylaw took effect.

Richard Stanwick, MD, professor of social and preventive medicine at the University of Manitoba here and author of the survey, said he is delighted with the results, especially since the restaurant association opposed the bylaw when it was first introduced in 1983.

"We were actually quite surprised given the low level of public education and enforcement by city officials.

"Obviously, we can count on business as an ally rather than an opponent for other clean-indoor-air acts."

Participating retail stores included a cross-section of 490 retail outlets in major shopping centres, residential areas, and strip malls. Only two-thirds of them considered their sales areas no-smoking, and less than one-third had no-smoking signs displayed, a requirement under the law.

Tobacco use up worldwide

By Thomas Land

GENEVA — Despite exhortations from doctors, teachers, and the mass communication media, cigarette consumption is still growing faster than population increases, generating enormous health risks for the future.

Statistics from the United Nations World Health Organization (WHO), indicate the highest rates of cigarette consumption per capita and the highest lung cancer mortality rates still occur in industrialized countries, particularly North America and Britain (**The Journal**, January).

But, the steepest rise in the last decade has been in poor countries.

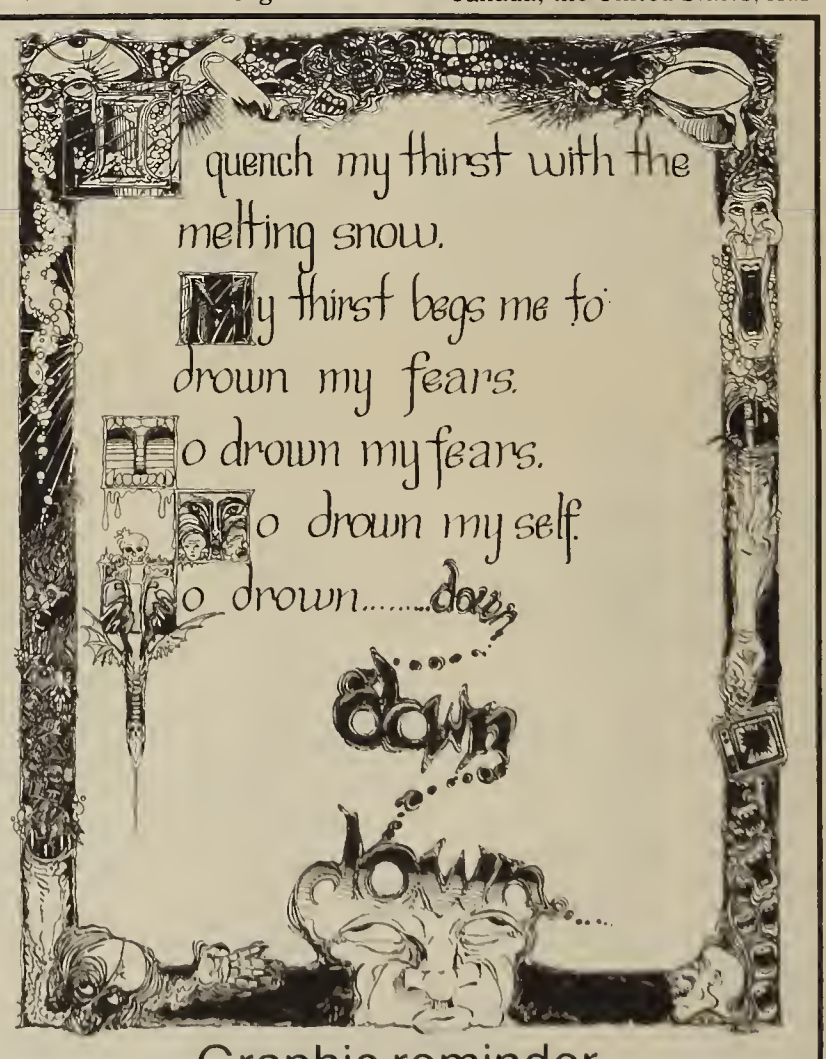
In five industrialized countries — Canada, the United States, Australia, New Zealand, and Japan — the number of cigarettes smoked has increased by 14% against a population growth of 12.9%.

Cigarette consumption in Africa is nearly twice the population increase, jumping by 42% against a population increase of 23%. In Latin America, the number of cigarettes smoked increased by 31% and in Asia by 29%, significantly more than the adult population growths of 25% and 22% respectively.

The analysis is based on tobacco production, imports, and exports; it does not take into account various "cottage industry" forms of cigarette manufacture.

Despite indications of increasing lung cancer mortality in the developing regions, the WHO says many governments there are ambivalent on the issue, allowing the tobacco industry to expand unchecked in order to raise welcome tax revenues.

It emphasizes that the health risk is particularly acute in the developing countries because the cigarettes marketed there contain more nicotine and produce more tar and carbon monoxide than do cigarettes available in the industrialized world.



Graphic reminder

Concern for peers and friends caught in the downward spiral of addiction prompted the design of this poster by a young Scarborough, Ontario artist. The original illustration and poem, the work of 15-year-old Matthew Sloly, are on display at the Addiction Research Foundation in Toronto.

Koop calls smokers out — twice

WASHINGTON — Evidence about the effects of second-hand smoke is now so compelling new measures are needed to restrict smoking, says United States Surgeon-General Everett Koop, MD.

Dr Koop, in releasing a report concentrating on non-smokers, said it is now clear that damage due to the inhalation of tobacco smoke is not solely limited to smokers; it also affects non-smokers.

He added: "The rights of smokers stop at the point where his or her smoking competes with those occupying the same environment."

The only answer is a smoke-free workplace and smoke-free public buildings. Parents must also do their best to eliminate tobacco smoke from the environment of their children.

Some critics have said no action should be taken until more evidence is available about the effects of second-hand smoke.

Dr Koop, as both a doctor and a public health official, says: "It is my judgement that the time for debate has passed and measures to protect the public health are required now. Scientific evidence is more than sufficient to justify remedial action."

New Brunswick survey shows

Teens choose to drink

FREDERICTON — Alcohol is the drug most commonly used by New Brunswick secondary school students, with tobacco and cannabis running a distant second and third, a new survey indicates.

And, approximately 25% of those surveyed by the province's Alcohol and Drug Dependency Commission (ADDC) report blacking out while drinking.

In the survey, more than 6,000 student volunteers were interviewed in a four-day period in all parts of the province. (There are approximately 70,000 students in NB junior and senior high schools.) More than 70% reported alcohol use at least once in the last year.

During the same period, 44% used tobacco (at least once), and 23% had been at least one-time users of cannabis.

The next most prevalent drugs were prescribed barbiturates and non-prescription stimulants, with 13.2% and 10.1% of students, respectively, reporting use.

On average, 30% of the students surveyed report having been on a drinking spree at least once, ranging from 13.6% of Grade seven students to 44.4% of Grade 12 students.

The two most common reasons given for using alcohol and cannabis were "to see what it was like," and, "because my friends are using it."

COMMENT

GILBERT

UK's Addiction Research Unit

Four years ago, I wrote two columns about the work of the Addiction Research Unit (ARU) of Maudsley Hospital in London, Britain's leading centre for research into the addictions (April, March, 1983). I visited the centre again in January. What follows is a brief update of some of the matters covered in my previous reports and an indication of the Unit's current work.

Careers of alcoholics

The main interest of ARU director Griffith Edwards, MD, continues to be the careers of alcoholics. The Unit is still in touch with approximately two-thirds of a group of 99 male alcoholics interviewed during the early 1970s. A 1985 report in the *British Journal of Addiction* showed a trend away from what the authors described as "troubled" drinking during the first decade of scrutiny of the group, illustrated by this summary of data from the study:

Drinking behavior during the year

	1972	*1981*
Troubled only	41%	37%
Troubled and social	24%	12%
Social only	3%	9%
Social and abstinent	17%	12%
Abstinent only	15%	30%

The trend of the group toward abstinence and social drinking obscures considerable individual movement among categories from year to year. According to the 1985 report, ". . . 60% of the individuals have a patchwork of abstinence and troubled drinking."

The current focus is on identifying "change episodes" within drinking careers. These are events and experiences reported by the subjects that precede, accompany, and follow changes in the patterns of alcohol consumption. Hundreds of pages of transcripts of interviews are being coded to identify common features of, for example, a shift from abstinence to social drinking.

Part of the interest in careers of alcoholics concerns the extent to which 'social' or 'normal' drinking occurs during or after recovery — defined as regular use of alcohol, but never more than five average drinks in any 24-hour period and no dependence symptoms or other adverse consequences.

Elusiveness of truth

A seminal study of social drinking by recovered alcoholics was published in 1962 by D. L. Davies, head of Alcoholism Treatment Services at the Maudsley Hospital. His report in the *Journal of Studies on Alcohol*, Normal drinking in recovered alcohol addicts, concerned seven men previously suffering from alcoholism who were reported as drinking normally for periods of seven to 11 years after discharge from hospital. The report was influential in combatting the view, espoused by Alcoholics Anonymous, that social drinking by an alcoholic is an impossibility.

Dr Edwards examined Dr Davies' seven patients or their relatives. He concluded: ". . . Five subjects experienced significant drinking problems both during Dr Davies' original follow-up period and subsequently . . . , and the two remaining subjects (one of whom was never severely dependent on alcohol) engaged in trouble-free drinking over the total period."

The recent work on careers of alcoholics enables us to be less than surprised by the review of Dr Davies' work. An alcoholic can be abstinent, drink socially, and engage in troubled drinking at various points of a mostly unpredictable career. A researcher unaware of the variety and variability of alcohol careers might easily conclude that a certain pattern exists where there is none.

Had the reassessment of Dr Davies' work occurred without the present understanding of the liability of alcoholics' careers, today's reviewers might have been tempted to accuse Dr Davies of sloppiness or even misrepresentation. Now, Dr Davies' work stands merely "as an indication of the elusiveness of truth," said Dr Edwards. He added: "We have woven pretty stories without verifying them. Papers [on alcoholism] are riddled with statements that are difficult to verify."

The work on careers of alcoholics continues, but, since 1983, there has been a shift in the ARU away from research into alcohol problems and toward work on the use of heroin and other 'hard' drugs.

A brief update of some matters covered in previous reports and an indication of the Unit's current work

GPs and opiate abuse

A significant part of the work on 'hard' drugs concerns the role of general practitioners in the treatment of drug abuse. Until the late 1960s in Britain, most treatment of users of 'hard' drugs was done by GPs, the main source of the notification of such users required by the national government.

Then, Drug Dependence Units (DDUs) were established to provide the expert care not available from most GPs. By 1970, the DDUs were making 85% of the statutory notifications. As the number of abusers grew during the 1970s, GPs gradually came back into the picture because of the long waiting lists for first appointments at the DDUs and the uneven distribution of DDUs about the country.

By 1984, GPs were making 55% of the notifications. Researchers at the ARU, particularly Alan Glanz and Colin Taylor, began to survey GPs about their contact with, management of, and attitudes toward opiate misusers.

The findings were published in three articles in the *British Medical Journal* (August, 1986). They suggest:

- About one in five GPs sees an opiate misuser in any given month. One third of the time, the patient is "new" to the GP. The national annual total is 30,000 to 44,000 such new paticnts.
- In more than half of cases, the opiate misuse will have been under treatment by the GP for longer than six months, with opiate drugs prescribed in nearly a third of cases. Only a third of cases are notified to government.
- GPs consider opiate misusers to be "especially difficult to manage, beyond their competence to treat, and less acceptable as patients than others in need of care." Indeed, only 31% of the survey's respondents said they would treat an opiate misuser as willingly as any other type of patient in need of care.

The prescribed opiate is generally methadone. Contrary to myth, heroin was prescribed in Britain only during the period 1968 to 1972, said Mr Glanz.

No special licence is required to prescribe methadone. There is a move toward no prescribing at all, even though unavailability of methadone has contributed to illegal opiate use.

Mr Glanz and Mr Taylor are now preparing a study of the obstacles to greater involvement by GPs in treating opiate abuse. Among the obstacles, real and perceived, are: lack of skill; the view that drug abuse is not a priority because it is self-inflicted; devious, disruptive patients; and, the disproportionate effort required in relation to results achieved.

The simple way to encourage what Dr Edwards regards as the desirable trend toward the treatment of opiate users by GPs would be to pay GPs to undertake special training and to treat drug misusers. The British government rejected this option. Meanwhile, the DDUs retreat to providing occasional expert support for mostly inexpert GPs.

The large difference found in the ARU survey between official and actual numbers of drug users points to the need for a better system of identifying and tracking users. The ARU is working on the design of a national monitoring system, to be managed by the ARU, that would provide good current information in spite of overburdened GPs and the diversity of agencies involved in the care of drug abusers. Thoughts are also turning to securing better information about drug abuse in continental Europe.

GPs and alcohol abuse

The reluctance of GPs to treat opiate abusers parallels a longer-standing problem regarding the treatment of alcohol abuse. Betsy Thom and Carlos Téllez of the ARU recently reported in the *British Journal of Addiction* 33 interviews with GPs concerning their diagnoses of alcohol problems, attempts at treatment, and use of hospital services. These researchers showed how "the diagnosis of drinking problems, particularly in the early stages, poses intellectual and emotional difficulties for GPs, notably because they must first define as a problem, behavior that is generally regarded as normal and desirable, and secondly because they must do so despite doubts about the likely success of their efforts to help people with drinking problems."

Ms Thom and Mr Téllez conclude: "Strategies to improve the medical response to drinking problems are likely to achieve limited success unless they are supported by wider political measures aimed at altering public perceptions of the use of alcohol."

Nicotine therapy

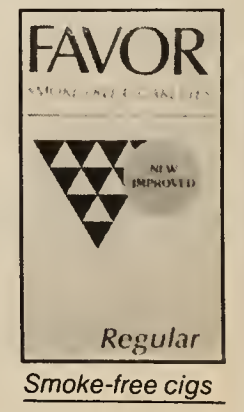
Smoking research, directed by Michael Russell, MD, continues to form a major part of the ARU's work. An ongoing theme is the notion that regular smokers are dependent on nicotine and successful therapy may require sustaining nicotine dependence, at least for a time, by means of a less harmful vehicle for nicotine than tobacco smoke. Nicotine chewing gum is the best known example of an alternative vehicle.

In the earlier columns, I described research at the ARU on the acceptability and efficacy of nasal nicotine solution (NNS), a form of liquid snuff squeezed into the nostril to provide rapid delivery of nicotine to the central nervous system. A clinical trial has now shown that NNS is moderately acceptable to quitting smokers and produces fewer side-effects than nicotine gum.

Another promising approach has been transdermal delivery of nicotine by nicotine-containing skin patches. Absorption is slow, even slower than from nicotine gum, but side-effects are few.

Smoke-free cigarettes

A recent, unpublished study examined smoke-free cigarettes, a product being market-tested in the United States. Each consists of a hollow, white, plastic cylinder, similar in proportions to a regular cigarette, with imitation cork tipping paper at one end and a plug of porous plastic sponge impregnated with nicotine at the other. Sucking at the tube delivers a mixture of air and nicotine. A typical puff at a fresh, smoke-free cigarette delivers about 13 micrograms of nicotine, compared with 100 micrograms from a regular cigarette.



Smoke-free cigs

The authors conclude: "The results were a mixture of disappointment and cause for cautious optimism. On the negative side, there was little evidence of the capacity of the smoke-free cigarettes to deliver potentially useful doses of nicotine to the alveoli of the lungs. On the other hand, they do appear to be capable of generating slow but substantial increases in blood nicotine concentrations of an order similar to those produced by nicotine gum and could therefore be of therapeutic value."

The point of investigating a variety of vehicles for delivering nicotine is that, although nicotine therapy is generally more effective than other methods, any one method might not be found acceptable to a particular quitter.

Nicotine gum for life

Dr Russell, and most physicians, regard nicotine therapy as a useful way-station between smoking and a nicotine-free existence.

The experience of a friend of mine is cautionary; Graham Reed, a psychology professor at York University, Toronto, tried to quit smoking for 36 years before he began using nicotine chewing gum in 1983. He still uses the gum, feels he will use it for the rest of his life, and that if his family physician denied him a continuing prescription, he would immediately resort to cigarettes.

Dr Reed has kept good records of his gum use. He has interesting insights into his lifelong grappling with nicotine that I'll describe next month.


Glanz: contrary to myth


Russell: useful way-stations

By Richard Gilbert

The Journal

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Early intervention draws reader reaction . . .

. . . provocative

I found the article on early-stage problem drinkers (January) to be thought provoking.

I am somewhat confused because I assume many of these "problem drinkers" were already genetically programmed to develop into full-blown alcoholics. To imply that they could drink "defensively" or "safely" might be somewhat misleading.

I could see such an approach could work for some patients and would be helpful for others with the understanding that, "If this doesn't work for you, maybe we need to consider some genetic reasons for your drinking problem."

I would appreciate more information on this program. Is the manual available for purchase?

Burt Wasserman
Substance abuse counsellor
Staunton, Virginia

. . . astounding

Early intervention???

I must confess I was nothing short of astounded by the article, Warding off the crash (January).

To hear you state, "The program is not designed for severe alcoholics but for people like Joanna, with less than 10 years of excessive drinking," absolutely amazes me.

I cannot imagine considering working with people who have been drinking for up to 10 years as "early intervention," or that these people are not "severe alcoholics."

Joanna, the woman discussed in the article, who was considered in this category of drinkers, drank eight to 10 drinks per day for six years and was experiencing blackouts at the time of the "early intervention."

As part of Joanna's treatment, she was allowed more than three drinks per day (three mixed drinks and one sherry) as a "reward" for not drinking more. Assuming this was allowed seven days per week, this would be more than the definition of moderation in drinking as spelled out in the same article "seldom drinking more than three times per week."

Certainly, we as care-givers working with alcohol and other drug abusers are not to be expected to take this article or program seriously?

Jack Vandenberg
Orillia, Ontario

. . . interesting

I read with great interest the article, Warding off the crash (January).

I agree wholeheartedly with this concept and would be very interested in learning more about this program set up at the Addiction Research Foundation, Toronto.

Would it be possible to receive a copy of *Why Not Drink Defensively: A Self-Help Manual for Drinking Safely*? I would also be interested in making a contact with someone trained in this field and practicing in the Ottawa area.

Terry Lavender
Nepean, Ontario

(Editor's note: Martha Sanchez-Craig, PhD, founder of the early intervention program detailed in the January article, is answering your questions directly.)

Nurses supply patients with courage — or terror

I am responding to Elda Hauschildt's article, Addictions in nursing: reality versus image" (December, 1986).

As founder of Project Turnabout and an esteemed nurse of long standing, Janet Gaskin certainly knows more about nurses and their problems than I do.

However, I question two of her statements: "Nursing is likely to be a small part of patient care . . .," and, "If the patient is only in hospital three to five days and you have all these other care givers, how much time do the nurse and patient get?"

Last summer, I was hospitalized for one week for a problem that had nothing to do with addiction.

In my experience during that short time, I found nursing was a huge part of patient care. In fact, there were no other care givers to speak of. The good nurses supplied courage as well as needles, painrelievers, and fresh blankets. The bad nurses were sources of terror and made me feel as though being sick were somehow my own fault.

My point? Nurses have every opportunity for "gratification" and "job satisfaction" if they can find it in helping the sick.

I do not deny their special difficulties, but am convinced that they are extremely important links in the healing chain, often with more power for good — or evil — than they realize.

Lise Anglin
Senior research assistant
Drinking/Driving Research Unit
Addiction Research Foundation
Toronto, Ontario

Inside Out right on target

Thank you for an interesting and informative publication.

As a person who for years had a severe alcohol problem and who is now in recovery and rebuilding a new life, I find the column *Inside Out* very interesting.

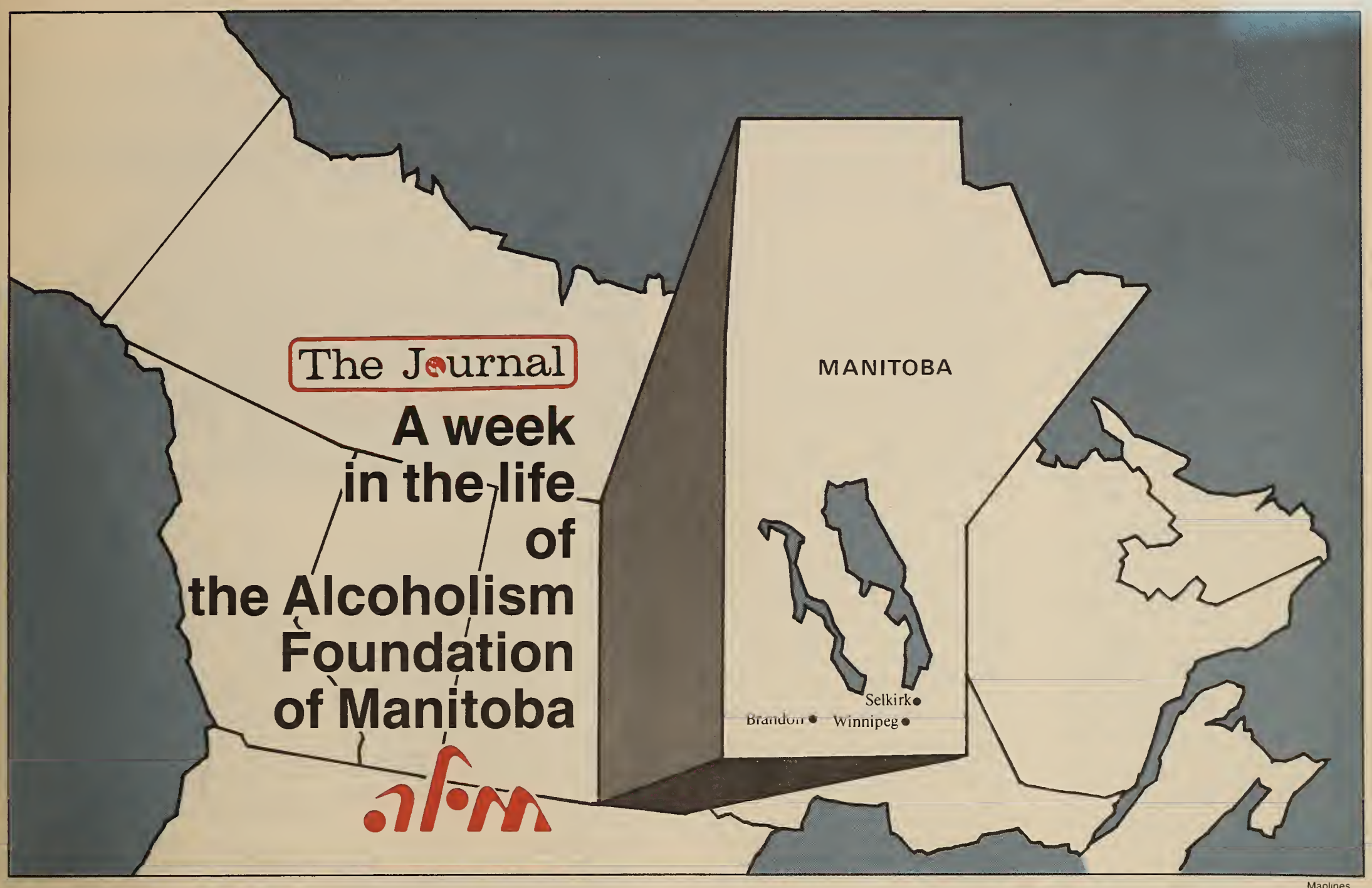
Having discussed feelings with many alcoholics, I find we have difficulty putting these feelings into words. The author of *Inside Out* explains these feelings in a manner of someone who's been there. He shows the mood swings, the seeking of something to believe in again, the fragility of sobriety.

Also, he explains the feeling of listening to alcoholics share their experiences and the feelings derived from this.

I'm presently doing volunteer work within a treatment program. I feel articles like *Inside Out* would be of great help to clients within treatment programs.

A. Reid
Mississauga, Ontario

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: **The Journal**, 33 Russell St, Toronto, Canada M5S 2S1.

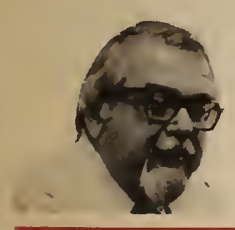


Maplines

WINNIPEG — It's February, and the snowplows, big and small, slash their way down the main roads here as the last of an overnight snow slowly peters out — the first heavy snowfall since the city was buried by a blizzard in early November.

As the cab slithers toward the Alcoholism Foundation of Manitoba (AFM) office on Portage Avenue, the driver, like everyone else here, says that until now, this has been the mildest winter in years in Manitoba. This week, the temperature falls to minus 35 degrees celsius.

In this report, the fourth in The Journal series on Canadian provincial addiction agencies (Ontario, October, 1986; Alberta, August, 1985; and, Nova Scotia, November, 1984), Washington Contributing Editor Harvey McConnell looks at the AFM, its programs and objectives, its future directions.



Harvey McConnell reports from Winnipeg

THE DIARY

The AFM — everyone is expecting the name to change to include either drugs and/or addiction — has seen a massive number of changes, from the top down, in the last year. Former executive director Ross Ramsey stepped down last spring to move to a plum job with the Kaiser Substance Abuse Foundation in British Columbia (**The Journal**, April, 1986), and Ian Puchlik, the director of support services, took over here in the summer.

It is also a time of zero budget growth, or even possible budget-shaving, with strict accounting and accountability.

As an independent, provincial Crown agency, the AFM received approximately $10 million from the government last year. Of that, approximately 60% was used by the Foundation itself, and 40% was distributed to outside agencies, including: the Salvation Army Harbour Light residential program, the Main Street Project which deals with people in the core area here, the Native Alcoholism Council (while only 6% of the province's population is Native, close to 50% of AFM clients are Native), the St Norbert Foundation, and a detox facility in The Pas receive partial funding.

Judge Charles N. Rubin, AFM chairman, says the Foundation's role is to "make sure the services we acquire from funded agencies are being directed in the same manner, philosophically, that we see within our own community.

"There are many agencies assisting various aspects of addictions problems. Some of them centre more on shelter situations than on addictions. You have to skate in between them, so to speak, in terms of funding because there is only a limited amount of money and there is a serious problem with restraint. Funds have to be jealously distributed in the best possible fashion."

Judge Rubin says the greatest need in Manitoba right now is for addictions services for youth. The AFM has tried unsuccessfully for the past three years to obtain special funding for a youth program.

"We see a crying need. There isn't any serious direction taken with respect to addictions problems among young people. That's our next goal — to create or at least try to obtain funding to create a youth initiative."

He takes pride in knowing the AFM "has achieved a presence in the province and is well-known. We have a tremendous working relationship with community groups, particularly AA (Alcoholics Anonymous), which is enormously supportive and provides a great deal of aftercare and follow-up for Foundation clients."

MONDAY

11 am
AFM Headquarters
Winnipeg

Ian Puchlik's appointment as AFM executive director has been made more exciting by the development of a national drug strategy in Canada (**The Journal**, December, 1986). Less exciting, but just as real, are strict budget clamps in difficult economic times.

This is the perfect spot for a centrist. That is where Manitoba is located in Canada and probably what most people here feel. Mr Puchlik: "We feel very much just plain in the middle. We certainly don't feel any close ties with Ontario or places east, but we do feel an association of sorts with other prairie provinces.

"Even when it comes to drinking in Canada, we are in the middle. If there is such a thing as a typical drinker, we would have it. The smaller per capita consumptions are to the east of us, and the largest per capita consumptions are to the west of us."

The inklings are that his next budget might have to result in necessary cuts here and there in programs and personnel, something Mr Puchlik does not relish.

He is enthusiastic about the developing federal strategy and looked forward to a Vancouver meeting the following week with other provincial agency directors. (Mr Puchlik said, following the meeting, he was extremely encouraged, as well as intrigued to find out how much programs vary between provinces.)

He and the other directors, he's sure, would like to see more cost sharing with the federal government for alcohol and other drug programs.

"I guess that's why I'm encouraged that the federal government is developing a national strategy even if it doesn't result in us getting more money. As long as somebody in the province and in the field gets more, it will be good."

As to the disproportionate number of Natives in AFM programs, Mr Puchlik points out executives, bank presidents, or other higher-income groups tend to go outside the province for help. Therefore, most of the AFM clients are in the middle- and lower-income categories.

"And, it's probably true in other treatment agencies in Canada."

The AFM's latest initiative has created a mystery: since September, an impaired driver's program — under which people convicted of driving while impaired (DWI) have to come to the AFM for assessment and possibly a one-day educational seminar or treatment, if necessary, before getting their licences back — has been in operation. Darlene Golinoski and a fully trained staff have been prepared.

But, where are the drivers convicted of DWI and who, one would think, would want their driving licences back?

Mr Puchlik: "Here it is mid-winter, and the numbers just aren't surfacing."

There are a couple of unlikely probabilities: "One possibility is that people have decided they are going to drive unlicensed and uninsured. The other is that these peo-

(continued on page M2)

Rubin: philosophic similarity

Puchlik: encouraged, intrigued

(from page M1)

ple have given up driving and have no intention of trying to get their licences back."

Mr Puchlik says one of the points in seeking government approval for the impaired driver's program is that the program will be fully cost recoverable.

If the numbers don't improve, Mr Puchlik plans to get together with relevant officials to try to solve the mystery of the missing DWI drivers. It could be, he mused, that laws on driving unlicensed and uninsured need to be tightened up.

Mr Puchlik says in the treatment field, Natives have a choice of entering programs geared to their culture or regular programs. "We felt we wouldn't try to duplicate (what they have). We decided to continue our program as we had it, but at the same time to become more aware of cultural differences when dealing with Native patients."

While budget constraints are certainly a minus, one of the pluses Mr Puchlik sees is that the agency can encourage "increased public awareness about alcohol and drugs and their effects.

"I think our field is becoming better known in the mind of the public: for example, impaired driving — everyone is buying into a part of it, employee assistance programs and industry. Everyone is more aware.

"I think our agency has a visibility higher than what it was, and I think that is something we should continue to work on — not necessarily just (visibility for) the agency, but for the field, being a catalyst to get information out on alcohol and alcoholism."

Mr Puchlik sees an attitude change in society generally: "I know from parties I go to that a few years ago, people would get absolutely bombed, get into their cars, and drive home. Now the talk of the party is, 'Who is your designated driver?'

"People are becoming more aware of their (own) consumption. And I've noticed something that never happened before: people put out coffee around midnight and say, 'One for the road.' That's the coffee."

And a good party question is to ask how many drinks people think they can have before they reach the legal blood alcohol (0.08%) limit.

"Most people haven't got a clue.

"They don't know whether it is two (drinks) per hour, or six in four hours. I found this out when I took a breath tester to a party given by my brother. To a man, everyone was shocked at how little it takes to reach 0.08%."

Although the legal drinking age in Manitoba is only 18 years, the province doesn't have to worry about teenagers from North Dakota (where the legal drinking age is 21 years) crossing the border for a night out. Roads across the Manitoba/United States border are few, and so are any large towns adjacent to it.

Noises have been made in the past about raising the legal drinking age in Manitoba to 19 years, but Mr Puchlik says, while it would take the limit past the high-school age, the impact would be small.

"But, if you wanted to raise it to 21 years, then I think there would be a significant effect."

One aspect of the Manitoba licensing system he finds worrying is the legal sale of alcohol by corner grocery stores in small communities.

"I know what it means because I live in a small community outside Winnipeg called Birds Hill. The store has a liquor licence. I know I've gone there for other things and thought, 'Yes, we could use another bottle of wine.' Now, if I didn't see it, I wouldn't have bought that bottle of wine.

"If they did that all around Winnipeg in the big stores, there is no doubt consumption would go up. Let's not take the risk."

1:30 pm
Youth unit

Teenagers referred to AFM's youth treatment unit will find Sherry Palmer, acting supervisor, youthful (assuming they don't consign anyone more than 25 years to the realms of senility).

She has experience in the corrections field and with AFM as a networker in community relations, with involvement with outside agencies.

Attitudes in the unit are realistic: the goal is abstinence, but there is acceptance that the majority won't stick to it. A change in some aspect of clients' lives and involvement of parents is a constant challenge.

Some 450 teenagers aged 12 to 18 years went through the program in 1986. About 50% came to AFM through the correctional system, and almost all of the rest were referred by family agencies or parents. Only 3% of clients voluntarily seek help.

Ms Palmer says the youth program "has only been here for about five years, a relatively new development."

About half of the teenagers attend the program for five days after school; the other 50% go into a three-week treatment program. Counsellors help them assess their patterns of use and abuse and impart an educational component.

Ms Palmer says there is a six-month follow-up for everyone and an even longer one for those who enter treatment.

"Our goal with chemically dependent kids is that they maintain abstinence. But realistically, we know that is not always going to be the case. If we can see positive changes in their lives, we consider them to be a success."

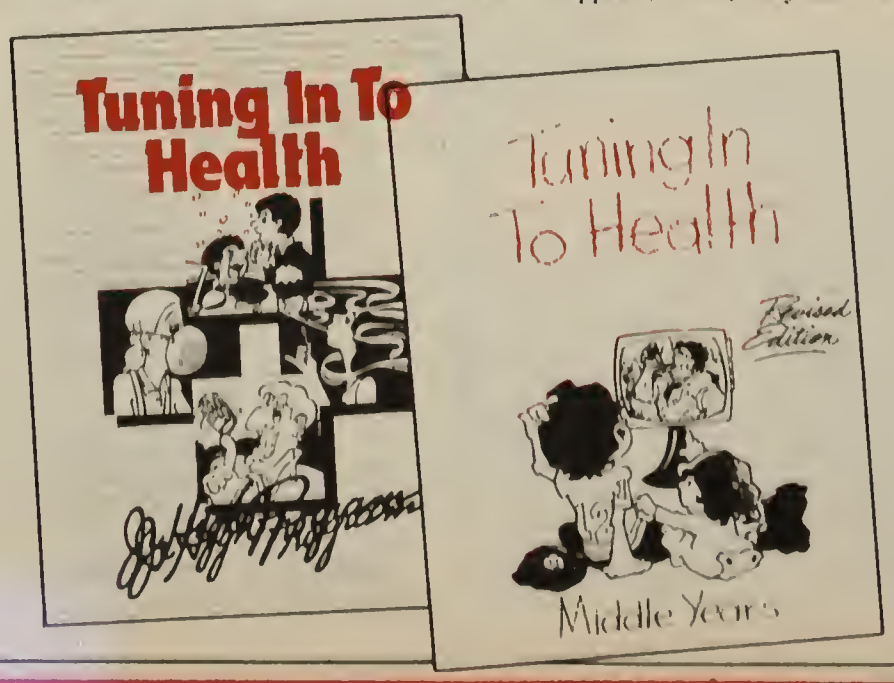
Alcohol is the most used drug, "but a very close second is (cannabis) - marijuana, hashish, and hash oil. Most of the kids are into daily use, or use every second day at least."

Break and enter and drug dealing are the major crimes for those who come through the correctional system.

The new Young Offenders Act means the unit now services teenagers from rural areas; about 100 kids from northern Manitoba are living in open custody in Winnipeg, attending the program. Approximately 50% of the clients are Natives. Many of them also sniff solvents and gasoline.

Many preteens in Winnipeg also sniff (**The Journal**, August, 1986). Ms Palmer explains "By the age of 13 years, there is peer pressure. Sniffing is not seen as very cool or sophisticated, so many switch to alcohol and marijuana. However, for those who live in the more remote rural areas, there may not be that much peer pressure to stop or change. They could have started sniffing at seven or eight years and at 15 or 16 years, they are still sniffing."

Above all, sniffers are extemely difficult to help: many come to the unit once and then disappear; often, they don't attend



A week in the life Alcoholism Foundation

school either. Unless the AFM unit can step in, they won't get help.

As many parents of teen clients as possible are invited to take part in a program for family members. But reality, again, is that parents spend so many days or evenings with counsellors or waiting outside courtrooms, they are exhausted.

"About 25% of our parents attend the sessions: we wish it were more.

"We have found that most families are not dysfunctional until their kids start using. Then, the question of control becomes an issue. Many kids are running the home by intimidation or physical threats."

3:30 pm
Prevention

"We think we have something pretty unusual here in our Tuning In To Health program for elementary and junior high school students (**The Journal**, September, 1984). In fact, our folders and our revised program are hot off the press, literally," says Denise Koss, prevention consultant.

She and field worker Mark Strople revised the program for elementary schools piloted in 1983 and put into use in 1984. They also put the final polish on the junior high school curriculum piloted last year. Both are to go into effect immediately.

Ms Koss says that five years ago, the provincial Department of Education assessed the health education curriculum and decided a unit on drug use was needed. The ministry and AFM set up specific objectives for the curriculum together.

"It is not the kind of package we as an outside agency developed and are trying to fit into the schools. We already have endorsement and approval."

The original elementary-school pilot involved a series of sessions with teachers from various school divisions; the system has now evolved so that AFM regional offices coordinate the programs in their areas. This "gives teachers a good grounding in the program, its philosophy, and objectives," says Mr Strople.

Success breeds success and some hurt feelings too. Approximately 125 schools wanted to take part in the junior-high pilot.

Mr Strople: "We had the onerous task of deciding which schools would participate. We tried for a cross-section of urban and rural, small and large, private and public."

Ms Koss says a competent teacher can take the package and run with it the way it is. It is a complete package, aimed at the average student who is not using drugs.

"The purpose is to present information about substances on a fairly objective level and to discuss some of the emotional issues about making decisions."

TUESDAY

8:30 am
Winnipeg region
Selkirk

Herb Thomson outlines his job as the regional administrator of the Winnipeg region. He acts as local historian as we drive north along the Red River to Selkirk.

The area was settled by Scots, who had long, narrow lots with river frontage.

Today, most people there work in Winnipeg, and Selkirk advertises itself, especially for US visitors, as Catfish Country.

The main focus for adults in Winnipeg is the residential treatment centre next to AFM headquarters. A 15-bed primary care section helps men and women through chemical withdrawal.

The 20-day treatment for residential and non-residential men is held there; women are treated at River House a short distance away.

Mr Thompson: "We work to link the counsellor and client so that the client sees

Impaired drivers' program office

Thompson: local historian too

Manko: i

the
f Manitoba

the same counsellor from beginning to end. We work closely with NA (Narcotics Anonymous) and AA."

One of the changes being made "is to have Winnipeg staff move out a bit to service rural areas. Then, the staff in the rural areas can move out even further. It cuts down on travel time, and we think we deliver a better quality of service."

Across the frozen Red River in Selkirk, standing on its own, proud and happy, is Happy Thoughts School.

There is some question about how the school acquired the name a century or so ago, but there is no question of the fierce local opposition to suggestions the name be changed, explains Len Manko, school prineipal.

Mr Manko is chairman of the local HUB committee, a group of Selkirk people who voluntarily meet to discuss community problems.

Mr Manko: "We are a networking agency of representatives of various self-help groups. It evolved from a concern some years ago about an increasing vandalism and how to deal with it."

Over the years, awareness of the problems of chemical abuse grew, and a youth worker, Jan Harris, was hired.

From AFM's point of view, Mr Thompson says, "We are a resource, providing speakers, some financial assistance when required to put on some particular community project, and information sessions.

"We can't do it alone, we need the community committees."

While Mr Manko says awareness of the use of chemicals is increasing, "I don't think enough people are concerned about the use of alcohol and other drugs in a social setting.

"A soft approach may be better in the long run in educating people."

But, there has been one major change in community attitudes: "At one time, people used to point the finger at the school with respect to chemical abuse.

"Now, people are saying it is a community problem, and there is a partnership. They parent and we teach."

2 pm
Northern region

Glen Gordon lived in Thompson for 12 years and, as regional administrator for the probation service, knew exactly the kinds of problems he faced when he became AFM's regional administrator for the northern region four years ago. His region covers most of the large centres in the north not on Native treaty land. Fortunately, he can reach most by road, with the exception of the South Indian Lake area.

Thompson is a nickel mining town with a polyglot population; most of the rest of the people living in the region are Native.

"In many cases, families I saw while in the probation service, I now see in this job. There is a lot of alcohol and prescription drug abuse. On the reserves, there is a lot of sniffing — gasoline, hair spray, Lysol, and anything else they think is mood-altering."

Planes shuttle in and out of the region.

A bedevilling factor is that where there is a large Metis population, there is usually a hotel and an outlet for alcohol. Local band constables have authority on the reserves, but not in the Metis settlements.

"A good example is the Gods Lake Narrows reserve, which is dry. But, right in the middle is an island which is a Metis settlement, and that is where the liquor comes in. It is very frustrating from the point of view of the band constables who can't go in and close it down. They can only make arrests if people are caught on reserve land."

The Royal Canadian Mounted Police does what it can and has to deal with the aftermath of violence caused in large part by alcohol abuse.

"The major problem is economics, and, frankly, there is not much that can be done up there which is viable," Mr Gordon adds.

Any idea that the Native population could revert to its past traditions is out. "The land can't support all the people hunting, trapping, and fishing now. A lot of people have the mistaken idea the land is teeming with game; it isn't, and depletion would be rapid.

"And, the ban on fur products in so many places does not help. Outside people don't realize or understand that, for many people, trapping is their livelihood."

Mr Gordon observes that Native organizations, in the last three or four years, have become more sophisticated in their ability to deal with the government. "Things can be frustrating, but there is improvement over 10 years ago. In some ways it is not so bad. But, I don't want to minimize the problems we have."

4:30 pm
Program delivery

"In the winter, the road between Winnipeg and Portage La Prairie is considered the most dangerous in Canada because of blowing snow," explains Jerry Dragan, PhD, director of program delivery, as he threads through sheets of exhaust condensation onto the Trans-Canada Highway.

Fortunately, the night is clear, and blowing snow is not too bad as he slides the car into cruise control on a two-and-a-half-hour drive to Brandon and a meeting the following day with regional administrators.

He relates some of his background — education, the probation service, the one year he agreed to serve as director of the community corrections system in Manitoba and with it a number of necessary and sweeping changes, head of special projects for the provincial civil service — before joining the AFM two years ago. He spent two-and-a-half years in San Diego studying for a doctorate. He plans to retire there in the sun; "In Manitoba, we look for the summer and hope to get through the winter."

Dr Dragan says the difference in working with a private agency is that "you can act much more quickly and with less red tape." He tries to get out into the regions at least every six weeks and while he is in constant contact with the regional administrators and they often come to Winnipeg, "being in the field is really important to me."

A typical two days for him might include sitting in to watch staff do their jobs at a treatment centre one morning. He might participate, "if that seems useful.

"At lunch, I'd catch a regional advisory board, sharing ideas and assisting if I can on local issues. Later, I meet with the regional administrator; we review our programs and our progress toward our annual objectives. We have brainstorming sessions on issues that have come up."

Dr Dragan says one current study demonstrates savings to be made in Manitoba's health care costs, which at the moment consume one-third of the provincial budget.

Matched groups are being studied of those who go through a treatment program and those who receive only hospital emergency care.

"We go back one year prior to their coming to treatment. We check provincial health records and take a look at the incidence of use and cost per person, and then we follow them up, post-treatment, for as long as we can to see what the cost is per patient per year."

"The second group of people are diagnosed as alcoholic in emergency room visits but not treated for alcoholism.

"Already, in the early part of the study, we are seeing a significant difference between the treated group and the untreated in terms of the total amount of health care dollars the province spends for each."

In the untreated population, some clients attend emergency rooms as often as 42 times a year.

"We are trying to show the government that active intervention, whether in the workplace or in the community, is in the long-run going to save millions of dollars."

Dinner includes a rumination about the pluses and minuses of the addictions problems in the province and a recounting of what was found in Shamattawa, a reserve in the middle of nowhere near Churchill, (**The Journal**, August, 1976) and the scene of violence in the past two months.

WEDNESDAY

8 am
Western region
Brandon

Marston Grindey has lived in rural Manitoba for 20 years. Several years ago, after a long spell in the probation service, he joined the AFM as regional administrator for the western region. His area has a population of about 200,000, including the 38,000 people living here in Brandon.

Rural living can mean isolation; and people living 50 miles or more from Brandon or smaller offices, don't have all the services the AFM can provide. It generally means travelling to receive such service.

"Our service can only be on a intermittent basis, every week or so. It is a real problem for us," Mr Grindey says.

"Our alcohol treatment workers try to reach community health centres and hospitals to become familiar. They try to make contacts and make referrals. They try to get a regular schedule so people at least know they will be there on a Monday or Friday.

"The real problem for us is that people are treated and go back into the rural areas where aftercare is not as intensive."

Teenagers in the area are experienced with alcohol and others drugs; the western regional office is not set up to give them as much service as needed because of a staff shortage. Referrals are made to other agencies and efforts made to follow-up.

Overall, "alcohol is seen as a macho thing; it causes a lot of aggressive behavior. Alcohol far outshines other drug abuse problems," Mr Grindey adds.

Drinking is entwined with the popular sport of curling here.

"However," Mr Grindey says, "there is no question people are becoming more aware of alcohol and more aware of the problems if they are caught DWI. I know someone here in Brandon who owns a couple of hotels and his beverage sales are down about 30%. In the rural areas, it is even higher."

Always in touch with rural workers on his travels around the western region, Mr Grindey is on call on weekends for serious cases. "I'm not just an administrator. I don't back away from situations where I can get involved and that's what is required."

(continued on page M4)

St Norbert Foundation: funded agency

sing awareness

AFM Winnipeg: headquarters

DuBick: seat of our pants

Kolesar: vertical service

The Journal

A week in the life of the Alcoholism Foundation of Manitoba

(from page M3)

9 am
Sun Centre

Sun Centre is an old building partitioned and repartitioned over the years whenever the money or other facility is available. It will be abandoned, but for now serves admirably as a 24-bed treatment centre in the middle of Brandon.

Jim Fraser and his staff make it tick. Workmen have started to widen his comfortable but just-able-to-swing-a-cat office. A psychologist and retired 25-year Royal Canadian Air Force veteran, Mr Fraser set up several treatment programs in the services. He has been supervisor at Sun Centre for three years.

Like everyone else one talks to in the Foundation, he is enthusiastic: "I think what the Foundation is doing is realistic. It has its feet on the ground and is not chasing around doing a lot of airy-fairy things."

There is a lot of marijuana around Brandon to combine with alcohol; apparently, crack has made its debut. Rumor has it, and "one lad claimed he had had PCP, but from my experience I don't think so. There is not much cocaine and heroin here because of price and availability.

"Young users here are not sophisticated in drug use. They have no real experience, so they think they get whatever people claim they are selling them."

Sun Centre has a large number of Native clients: "Culturally, they are very private people; they have difficulty with what we know as communications techniques — simple things: there is little eye contact, they have a tendency not to be verbal, and they certainly don't like to discuss personal issues."

Kenzie Gray, a counsellor, agrees.

"I had to develop an ability to live with quiet; to be able to allow them (Native clients) two or three minutes between the time I ask the question or make a comment and the time they reply. In individual sessions especially, you can draw them out; they will talk when they have a level of trust and comfort that you will understand and be with them.

"Many tend to go back to their culture; to their spiritual beliefs. As soon as I, as a counsellor, feel they are happy with what they are doing — even if I am not myself — I am satisfied, especially since a part of our program is left up to the individual."

Native women are more reluctant to talk about battering and sex abuse. Mr Fraser thinks much of this is cultural: "They will accept more abuse than a white; they are much more passive."

On the other hand, Ms Gray says some of her most intense work has been with Native women.

There is one constant among Natives older than 40 years: the vivid memories of being forced into residential schools where attempts were made to take away all things Native and where white culture was forced on them. The Natives have nothing good to say for this intense experience.

Noon
Western advisory board

A soup and sandwich lunch has been arranged with Doug Wark, chairman of the AFM Western Region Advisory Board, and members Beverley Hicks, Gary Brawn, and Don Hamilton. As outsiders, they try to assess what the Foundation does, what it can do in their area, and to make appropriate suggestions. One of their concerns is the condition of the Sun Centre building; they fear it will just wear out one day.

Economics are never out of mind, Mr Hamilton notes: "Money is scarce in Manitoba as it is in the rest of the country. We want to get as much bang out of the buck as we can."

Mr Brawn: "Brandon is considered, even by the people who live here, a sheltered community; things which are common in larger centres take some time to get here. I think some years ago it could have been said, fairly, that there was no drug problem — not that drugs weren't available, in small quantities, to small groups of people. Now, there is a broader concern.

"There is greater sensitivity within the community to substance abuse in the broader sense. We know in the early grades in schools here, children are more sensitive; 10 years ago, youngsters probably had no appreciation of drug terminology. Even young children do now."

Matheson House: reflections of life in Brandon in the early 1900s

1:30 pm
Matheson House

Matheson House, the Foundation's western regional headquarters, has been refurbished to its original glory — round towers, balcony, intricate woodwork painted cream and green. A posthumous gift from a businessman here, it reflects life in the early part of the century: beautifully carved oak fireplaces, a stained glass window.

On the trip back to Winnipeg, Paul Madak, a native New Yorker and AFM coordinator of research and data systems, explains the computer system being installed. The snow forecast has come and gone in a whisk on the prairie winds; the road is long and fairly clear.

THURSDAY

8:30 am
Support services
Winnipeg

One of the newest members of the AFM is Tim Duprey, director of support services. He is familiar, like many other AFM staffers, with some situations the AFM faces because of his federal government experience, partly with the Bureau of Indian Affairs. His responsibilities include finance, personnel, recruitment, training and development, and labor relations. Foundation staff belong to the Manitoba Government Employees Association.

At the AFM, things are done in different ways in different regions. Mr Duprey explains: "Be it financial or program, each region has its own quality. The western region, for example, has a rural nature and rural attitudes. People take more time to meet and discuss with you.

"Winnipeg is urban — and a little more active."

11 am
Library

The Foundation's library is on the ground floor near the main entrance. This tempts people to walk in off the street to ask for information, librarian Rita Shreiber reports. Inquirers range from school children to university post-graduates.

A set of AFM pamphlets, in English and in French, are distributed widely. Language is couched in terms understandable at any reading level. Ms Shreiber says the AFM can't advertise the library service to the public: "We would not be able to handle the inquiries we would be sure to get."

An average of 350 video cassettes on topics that cover the field, from alcohol to solvent sniffing, are sent out each month.

11:30 am
Planning and research

"The first thing to do is to pinpoint opportunities and figure out how you are going to work within the system to get them," is how Linda DuBick sees part of her operation as director of planning and research. This is easier said than done.

Her career with the Manitoba government, before moving to the AFM 18 months ago, means she is trying to translate what she knows about the central government system, "and the big P and small p of politics, into the needs and concerns of the Foundation."

One AFM mandate is research, although there has never been capacity to conduct research. Paul Madak has been trying to develop such a capacity, but, as Ms DuBick points out, "the problem is, of course, that there isn't any money. So, we do a lot of things on spec and by the seat of our pants."

One thrust is to use the Foundation's staff and client population for graduate student research projects. The research review committee, which sets criteria and standards, recently met for the first time to consider two proposals.

A series of program evaluations is also underway to try to evaluate which programs are doing well and which are not.

Another important area is formulation of policy statements, which are both important and worrying to Ms Dubick. "I have a concern because I think sometimes when you define the differences between groups, you only make the problems worse. I want to see policies which almost could be applied to any human."

One of the first policy statements has been on care of women, and it addressed special needs such as child care, especially for single mothers, while in treatment. Obviously, the Foundation can't be a child care agency, but staff hope the means might be found to get women into treatment and contract out child care to local day care centres.

Golinoski: arguments with drivers

2 pm
Residential services

Gerry Kolesar is acting manager of the residential services located in a large building next to the AFM headquarters.

"We have units for 10 men and five for women for minor kinds of withdrawals before further assessment," he explains. "Women clients are treated at River House, and the men, in a 45-bed capacity in the building.

"We operate a vertical service; the same counsellor continues to see a client. This is much more effective than separate programs."

Non-residential care is soon to be located in the building as well as the affected persons' program: for people who do not have a problem themselves but have a family member who does.

A large number of the clients are Native. Mr Kolesar points out most live in Winnipeg and "have basically the same lifestyle as other people in the city. We have programs for those with special needs, which can be covered in indivdual counselling."

FRIDAY

9 am
Impaired drivers program

Since September, Darlene Golinoski and her staff have received abusive telephone calls from people hopping mad because a DWI conviction means they have to come in to see staff and part with $225. A lot have yet to come in.

"People on the telephone want to argue: they blame, they threaten. But, we have found that by the time they actually come in to pay their money and see a counsellor, they have already worked through a certain level of that anger."

Under the program, a DWI-convicted driver has to be assessed by Ms Golinoski's staff before applying to get their licence restored.

"We anticipate for first offenders that the great majority will be in the category of having made a stupid mistake. We will do assessments; if that is what comes out, we won't take further action."

On the other hand, people assessed as high risk in terms of consumption have to take part in a one-day educational program. The day is spent partly on education and partly on how to handle the situation differently the next time.

The 'next time' is not idle chatter. Ms Golinoski: "We try to assess what they're really going to do. We don't want only the 'right' answer — 'I'll take a bus.' Few young men, for example, are going to see a young lady home by bus."

If assessment shows a client's chemical use is already creating problems, the individual will be put into treatment.

People expect drivers put into treatment are going to be more hostile and more resistant because they're not there voluntarily.

Ms Golinoski is not so sure: "Perhaps that's right, but I tend to think that's a rather negative way of looking at it. Let's face it, how many people seek help? Something usually pushes them there.

"They might sit in a treatment group and say they don't want to be there, but want their licence back. It is more risky to say they don't want to be there, but they have to be because they want to keep their jobs or families. We might have an opportunity to deal more openly then."

The house where the impaired drivers program is located is in a quiet neighborhood. The AFM's first headquarters, it is anonymous enough for those who call.

And, Ms Golinoski is aware those who do come "have already suffered consequences: they can't drive, there is embarrassment as well as cost."

Participation in global anti-drug efforts seen as priority

Through the Open Door: China and drugs

By Gamini Seneviratne

VIENNA — China has no serious drug abuse problem as yet, but the world's most populous country has joined the international effort against drugs and is examining its own vulnerability.

China's commitment to an open door policy on the world has brought with it worries about an influx of drugs and the drug influence on youth.

The country's Criminal Code, reconstructed after the traumatic Cultural Revolution, includes an article which imposes severe penalties for drug smuggling and peddling. And, a new pharmaceuticals law closely controls the medical use of all addictive drugs.

The clearest revelation of concern is the 1984 decision of the State Council, the highest level of government, whieh led to the Ministry of Health immediately setting up a Drug Dependence Research Centre (DDRC).

While criminal law does not reflect internal demand and is aimed essentially against through-traffic of drugs in and out of China, the pharmaceuticals law does address a nascent problem. Drug dependence in China today is largely due to misuse in medical practice.

It is now illegal to use the opium poppy in traditional medicine and in the local pharmacy. One can buy acetylsalicylic acid (eg, Aspirin), vitamin C, and antibiotics like tetracycline, but not narcotics or psychotropic substances.

All addictive drugs are issued on prescription, and only physicians in practice for at least three years can prescribe them. For hypnotics, the prescriptions are limited to a few days' needs.

Chinese officials do not rate the prevailing level of post-treatment drug dependence as disturbing.

Cai Zhi-Ji, professor of pharmacology at Beijing Medical University: "Some people have developed dependence after getting narcotic injections against severe pain. Morphine is rarely used and the injectable analgesic of choice is pethidine (eg, Demerol).

Gilbert

China today: cultural conventions, traditional medicines, and international participation

"We also have some addiction due to the overuse of hypnotics, scattered cases of benzodiazepine and barbiturate addiction. The patients are required to accept treatment."

What does disturb Dr Cai and others is the future. Since the early 1980s, China has sensed its vulnerability to drugs and opted to be prepared; isolationism was abandoned for international participation.

In 1984, Dr Cai was elected by the United Nations Economic and Social Council to serve a five-year (1985-90) term as a member of the UN International Narcotics Control Board (INCB), the first Chinese member.

In 1985, China ratified the two international conventions and also joined Interpol (the International Criminal Police Commission).

As an INCB member, Dr Cai conveyed the international concern about methaqualone (eg, Tualone-300) to the authorities in China and recommended its manufacture and use there be stopped.

"I am happy to say steps are being taken to remove it from medical use, and, already, manufacturers in China have been asked to stop producing it," he told **The Journal**. (See story below.)

Dr Cai is director of the DDRC which, he says, has a key linking role.

"We want to collect information from all countries and translate and summarize it for the use of our authorities."

The external part of the DDRC program is being coordinated by the World Health Organization and has been awarded US $300,000 (Cdn $416,000) over three years, by the UN Fund for Drug Abuse Control. The funding will buy equipment, bring foreign experts to seminars in China, and send DDRC scientists to specialist centres abroad to fine tune their skills.

The DDRC is set up as an independent, non-governmental research body under the supervision of the Ministry of Health and is already earmarked by the government for status as a national institute, with appropriately increased staff and capability to carry out countrywide studies.

The single, most important of these is its planned epidemiological survey of drug abuse in China.

Almost as important, and already underway, are evaluation studies on the dependence potential of newly developed drugs.

The DDRC is also responsible for public education on smoking and alcohol, as well as on drugs. A related project is training of professionals who have contact with the public, notably doctors.

"There is a lot of concern about the young," says Dr Cai. "We have a very rough estimate that 70% of young people have the smoking habit, though not all are heavy smokers, only a few" (**The Journal**, June, 1986).

But, it is a social habit as well as a source of governmental revenue, so nothing other than information about its harmful effects is likely to come out of the Centre in the near future.

Alcohol, which is used only for rites and festivals, is seen as the least of China's problems.

Dr Cai: "Socially, we drink tea, so we have few alcohol addicts. We are becoming a bit worried now, because the economy is picking up and the young are exposed to the drinking habit."

An interesting bonus for China is that none of the herbs and plants used in its widely practiced traditional medicine, apart from cannabis and the opium poppy — both now illegal even for medical purposes — have any "detectable dependence potential," says Dr Cai.

It has been suggested, in fact, the low demand for drugs in China may be the result not only of cultural conventions, like tea rather than alcohol drinking, but also of traditional medicine based on whole plants rather than extracts of their active ingredients.

Mainland drugs hitting Hong Kong

By LachIan MacQuarrie

HONG KONG — Customs and narcotics officials are concerned the easy availability and relatively low prices of certain medicines in China may lead to a rising incidence of drug-related problems here.

The problems range from individual smuggling of medicines to trafficking and abuse of non-opiate drugs.

Customs and Excise Department Assistant Superintendent Michael Lee has warned Hong Kong residents of the medical and legal dangers of trying to take advantage of the low prices of Chinese drugs and the fact certain medicines, controlled here, are often available without prescription in China.

Major seizures of drugs originating in China have increased significantly, particularly of methaqualone, a commonly abused drug among bar girls and prostitutes in Hong Kong.

In the first six months of 1986, the total quantity of Mandrax (methaqualone-diphenhydramine) tablets and methaqualone powder seized was more than eight times that seized in the whole of 1985.

And, even though heroin continues to be the major drug of abuse for more than 90% of Hong Kong's estimated 40,000 addicts, there has been an increase of more than 200% in the number of people reported to be taking methaqualone as their primary drug.

HOWELL

Health promotion, the series

My dearest Nephew:

I have perused your latest missive with interest. I am always flattered when you turn to your old uncle for guidance in the ways of the world and for advice as to how you can best make your way in it.

I am no Lord Chesterfield and consequently my letters to you can be in no way as stylish and erudite as his letters to his son. But that *caveat* aside, I do possess a modicum of wisdom and a modest felicity of expression, and I am always pleased to apply both to the task of helping you chart your course through the stormy waters of life.

As I've told you many times, there are tides in the affairs of men, tides that can gently lift you into safe financial harbors and tides that can leave you with your keel stuck in the mud. Needless to say, the former are preferable to the latter. The trick, of course, is to be able to identify the flood tide from the ebb — something you have not always been successful at, as witnessed by your disastrous foray into Home Computers.

But, let us not dwell on past failures. Let us look to the future, and specifically, to your future.

I understand from your letter that you are now concentrating your efforts in the field of Health Promotion, a field you refer to as "the wave of the future." I seem to remember that 'the wave of the future' was the *sobriquet* with which you identified Home Computers. But, be that as it may, I wish you every success in your new endeavor.

Wishing you every success is one thing; your achieving it is quite another. And, I would be less than honest if I did not confess that I have some serious reservations about the health-promoting television screenplays you sent me.

I understand they are pilots for prime-time series, and I appreciate the difficulty of trying to create a memorable character and develop an interesting dramatic situation given the half-hour time limitation. But all that notwithstanding, I honestly do not feel that the NBC TV network is going to be impressed with *Hilda Hanover: Public Health Nurse*. The scene where she makes up a low-cholesterol diet for her roomate goes on far too long, and I didn't find the bit about her catching the Medical Officer of Health with his seatbelt unbuckled funny at all, even when I tried to imagine, as you suggested, Mary Tyler Moore playing the role.

In addition, I don't think CBS is likely to go for *Miami Virtue*. The premise is amusing — two Public Health Inspectors who moonlight as urine testers — but, how shall I say it, the pilot episode lacks a certain dramatic tension. The tedium of your duo's attempt to install adequate kitchen exhaust-fans in the restaurant of a Cuban exile is not relieved, I am sorry to say, by the sub-plot concerning the collection of specimens from the air traffic controllers at Miami International Airport.

It was perspicacious of you to send the *Zoltan Danzig* script to the CBC, a Canadian network with a reputation for being high-minded and public-spirited and, not only that, a network that has demonstrated in the past — by way of *Wojeck*, a series about a crusading coroner, and *Quentin Durgens*, a series about a hard-working Member of Parliament — that it is not only high-minded and public-spirited, it is also a network with a strange penchant for dramatic series about men with funny names.

Notwithstanding these favorable portends, I am not convinced the CBC will look on a series about a Statistics Canada biostatistician with much favor, even one so imaginatively named. And that is in spite of the scene in the pilot where Zoltan Danzig prepares a report about alcohol use in Elgin County, Ontario, and writes a memo suggesting that it would be quite interesting to compare this with alcohol consumption in Cape Breton.

I mention this scene because it was the only one that even remotely held my attention; the big dramatic moment when Zoltan Danzig discovers his boss sneaking a cigarette in the men's washroom, didn't move me at all.

I am sorry to sound so negative, dear nephew, but if Health Promotion truly is, as you say, the wave of the future, then you will need sleeker vessels than these to ferry you into Marina del Rey harbor and a California condo. Because, however much we might individually strive to live healthy and virtuous lives, the lives of the unhealthy and sinful have considerably more entertainment value.

How about making Hilda Hanover a public health nurse by day, and a call-girl by night? It is just a suggestion.

Your loving Uncle

By Wayne Howell

NEWS

More Irish students smoke — fewer use drugs

By Karen Birchard

DUBLIN — A major study of smoking and drug use among Irish secondary school students has found bad breath and smelly clothes are more effective deterrents to smoking than the threat of cancer or other health hazards.

Moreover, the study found smoking among high school students here is much more widespread than in Europe, North America, or Australia.

The study was conducted for the Economic and Social Research Institute (ESRI) by Joel Grube, a senior scientist with the Prevention Research Center in Berkeley, California who was with ESRI from 1981 to 1985, and Mark Morgan, a lecturer in education and pyschology at St Patrick's College here.

Of the students surveyed, 67% admitted they either had smoked or were still smoking. The average age for the first cigarette was 11 years, while many children admitted they began to smoke regularly between 13 and 14 years.

Approximately 3,000 students from a variety of social backgrounds, attending 24 randomly selected secondary schools in the Greater Dublin area, took part. More than a third used alcohol on a regular basis, and nearly 40% had been drunk at least once.

Twenty-five percent of the 13-year-old schoolboys surveyed were regular drinkers, while 70% of 17-year-old boys were.

However, the study points out that while there are a large number of teenage drinkers, there are also a significant number of total abstainers among the young.

"It's a major image of adult society," said Dr Morgan.

More than 20% of the students had tried drugs other than alcohol and cigarettes. 'Hard' drug abuse was low, with the least popular drugs being cocaine and opiates. The most popular drugs were marijuana and glue (for sniffing), followed by hallucinogenic mushrooms and cough syrup mixtures.

Comparisons with other countries suggest that although the rate of inhalant use here is high, the use of other drugs by Irish children is low by international standards.

But, the researchers point out, drug use had increased six-fold in 10 years.

The study found slightly greater use of drugs by students whose fathers hold either managerial or executive jobs. The consumption of drink or cigarettes by parents did not influence their children to smoke or drink. But, parental attitudes to other drug use did have some influence.

Neither the fathers' nor the mothers' work outside the home related to teenage drinking, smoking, or other drug use. Those students who had the most pocket money also reported more frequent use of the substances.

Young people who smoked, drank, or used other drugs were also found frequently to have behaviorial problems. As a group, they tended to swear and lie to teachers and parents, as well as to steal and damage property.

Perceived drug use by a best friend was consistently and strongly associated with student use of alcohol, cigarettes, or other drugs.

What the study report calls "bonding to the family" (close relationships with parents) coincided with significantly lower levels of drinking and smoking. Religious students and those who place emphasis on doing well in school were generally less likely to smoke or drink.

The study report points out more information about drugs does not seem to deter people from using them. In fact, there are indications information alone might lead to more favorable attitudes and increased experimentation.

It recommends school programs to combat cigarette, drug, and alcohol use, but says it is extremely important to avoid "miseducation." Information to young people should be truthful rather than exaggerated. By stressing immediate consequences of drug abuse, rather than long-term effects, teachers, parents, and counsellors have some effect.

Wanted: men, women for ADPA meet

WASHINGTON — A national conference on alcohol, drugs, and women scheduled for Denver in May had better draw a large male audience or Karst Besteman is going to be one miffed director of the Alcohol and Drug Problems Association of North America here

One reason for the conference is that "if you can show there is a gender difference in the consumption of various drugs, including alcohol, and that there is a social pattern, then you know you have to design your responses to meet those differences," Mr Besteman says.

This is important "because we haven't defined adequately treatment needs based on gender — male or female."

Mr Besteman points out there are some differences, there are clinical and epidemiological data available, and "we know some 90% of United States clinical directors and program directors are white, male, and middle-aged, or getting close to it.

"That particular population historically is not alert to gender differences in this field, or any field."

Mr Besteman emphasizes the May meeting "is not a for-women-only conference."

REVIEWS

New Books

by MARGY CHAN

Smoker Motivation: A Review of Contemporary Literature

. . . by Angelika Wettener and Jurgen von Troschke

This is a critical review of the social research literature on the smoker and causes of smoking. The review covers mostly publications in English and German issued since 1964, the date of the first United States Surgeon-General's report on smoking and health.

The text includes the main research findings and a critical analysis of methods and results. It focuses on three main aspects: commencement and habituation of smoking, changes in smoking behavior, and function of smoking from the standpoint of the average smoker. A comprehensive bibliography is appended.

Despite the large volume of literature on smoking, the book points out, almost all studies end on an inconclusive note. The limitation and methodological weaknesses of the various studies are discussed. This work will contribute toward the development of more sophisticated methodological and theoretical frameworks for future research.

Springer-Verlag, New York, NY. 1986. 164 p. ISBN 0-387-16751-X.

The Steel Drug: Cocaine in Perspective

. . . by Patricia G. Erickson, Edward M. Adlaf, Glenn F. Murray, and Reginald G. Smart

Even though cocaine has become a popular illicit drug among adults, information about the drug and its users remains relatively scarce.

This is a timely book on the current cocaine crisis (**The Journal**, February). The authors inject a sense of proportion to the issue by looking at cocaine historically, by placing it in a cultural context, and by reviewing available studies. The authors also present in-depth research on more than 100 adult cocaine users. Policy implications are discussed, and directions for future research are suggested.

The book will interest drug treatment professionals, law enforcement personnel, researchers, and those involved in the development of public policy.

Lexington Books, D.C. Heath and Company, Lexington, Mass. 169 p. $25. ISBN 0-669-14572-6.

Why Volunteers?: Selecting, Training, and Deploying Volunteers in Alcohol Treatment Services

. . . by Gillian Leigh, Robin Gerrish, and Evelyn Gillespie

In the last two decades, there has been an increasing emphasis on the role of community-based care in the provision of mental health services. Outpatient or neighborhood health care facilities have created a need for volunteers, especially in times of dwindling public funding.

In the alcohol abuse treatment area, volunteers are both a useful and necessary force in supplementing the growing need for services, including early treatment intervention and positive community links in maintaining treatment gains.

This manual explores the issues of selection, training, and deployment of volunteers. The appendix contains a detailed description of a volunteer program as a community support approach to alcohol abuse treatment.

Addiction Research Foundation, Toronto, Canada. 80 p. $9.75. ISBN 0-88868-104-2.

Prevention in the Drug Field

. . . by Sherri Torjman

This training package is the culmination of five years of research and effort by the National Planning Committee on Training in the Addictions Field, a working group of the Federal Provincial Sub-Committee on Alcohol and Other Drug Problems in Canada.

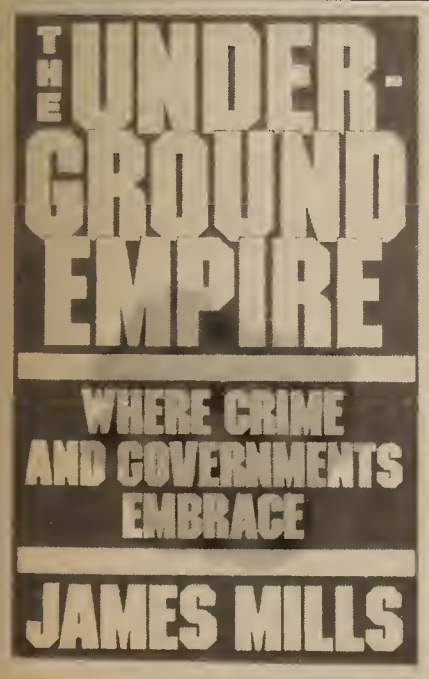
It provides a basic level of training developed primarily for trainers, but may also be useful to community workers with responsibility for prevention activities.

Prepared and written for use by many workers in the drug field, the package contains an instructor's manual and three monographs: essential concepts and strategies, change agent skills, and program planning and implementation. The training package is also issued in French.

Addiction Research Foundation, Toronto. $95 per package. ISBN 0-88868-126-7.

Guest Review

By Donald M. Smith, PhD*



Author James Mills is a journalist who purports to have spent several years gathering material for an inside account of CENTAC, the Central Tactical Unit which operated in the United States Drug Enforcement Administration (DEA) in the early 1980s.

Details are given on only three of CENTAC's projects against major drug traffickers, the common factor being the organizational acumen of the leaders involved. One conspiracy was centred in Fort Lauderdale, Florida, where Caribbean marijuana was imported. A second, in Tijuana, Mexico, pushed marijuana, cocaine, and some heroin from Mexico into California; and, the third — unsuccessfully resolved — involved heroin from the Golden Triangle through Thailand.

This book is a true crime adventure and could be turned into another violent television series.

Presumably, the author's inside track was given in an attempt to ensure survival of CENTAC and the type of wide-ranging investigation into major trafficking conspiracies, uninhibited by the 'turf' protection of regional DEA offices, it conducted. The effort was unsuccessful; the unit has long since been dissolved.

Such conspiracy cases are long, difficult, and don't yield the showy seizures of large quantities of drugs needed for the photo 'opportunities' sometimes used to help re-elect US district attorneys.

Of note is what is omitted: the involvement of the Mafia; Levantine trafficking; the Golden Crescent (Iran, Afghanistan, Pakistan) as a source of heroin; diversions from legal sources; motorcycle gangs and trafficking in synthetics; and, any in-depth study of methods used to track and seize the assets of traffickers and, more particularly, the financial operators who run them. The cases detailed were 'biggies,' but not the biggest or most-entrenched in the corruption of the countries concerned.

**Dr Smith is a former senior scientific adviser, intergovernmental and international affairs branch, Health and Welfare Canada.*

FILM REVIEWS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

The Party's Over

Number: 772.
Subject heading: Impaired driving.
Time: 19 min.
Synopsis: Jim, promising to get home in time for his son's party, goes off to work. After a normal day, he agrees to go for a beer with a co-worker. As Jim drinks in the bar, the narrator explains the dangers of drinking and driving and the three decisions each person must make: will you drink, how much, and will you drive? Several people tell of their experiences. Others explain why they do not drink and drive and the alternatives they use. By now, Jim is visibly impaired but sets out to drive home. After several close calls, he arrives. As he enters the house, his wife asks if he saw their son waiting for him in the driveway. Unknowingly, Jim has killed his son.
General evaluation: Very good (5.2). This film had great emotional impact and good information to stimulate discussion. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit those 15 years and older.

Medical Aspects of Co-dependency

Number: 771.
Subject heading: Alcohol and the family: treatment/rehabilitation.
Time: 28 min.
Synopsis: Max Schneider, an internal medicine specialist, has noticed members of families in which there is an alcoholic suffer from symptoms similar to those of an alcoholic. He lectures on the symptoms: psychosomatic disease, ulcers, and urinary tract disorders. He says all members of the family must receive treatment if they are to function smoothly as part of a family system. He recommends significant others — for example, the boss — also attend some treatment sessions.
General evaluation: Poor (2.1). The information could be misleading; not all family members manifest the symptoms shown, and not all families are "sick." The lecture format is boring.
Recommended use: With a resource person, the film could be used with families of alcoholics.

First Cigarette (Revised)

Number: 774.
Subject heading: Smoking.
Time: Nine min.
Synopsis: People who've tried cigarettes offer reasons for taking the first puff. People who continue to smoke discuss why. A third group discusses the difficulties of quitting. The viewer is cautioned to think carefully before accepting a cigarette.
General evaluation: Poor to fair (2.7). This film won't help the intended audience, young children, in making decisions about smoking.
Recommended use: None.

Living with an Alcoholic Parent

Number: 762.
Subject heading: Alcohol and the family.
Details: Two filmstrips with audio cassette tapes.
Synopsis: Maureen, Susannah, and Tom each live with an alcoholic parent. They explain their feelings and how they try to deal with their situations in the first filmstrip. The second illustrates the effects alcohol can have and tells why it is important for those living with an alcoholic to get help. The three tell how they got help from a school counsellor and Alateen.
General evaluation: Good (4.0). The filmstrips accurately portray how young people might react to an alcoholic parent and provide good advice on how to cope.
Recommended use: With a resource person, the filmstrips could benefit those 12 to 18 years of age.

PCP

Number: 773.
Subject heading: PCP.
Time: 19 min.
Synopsis: PCP, a very unpredictable psychoactive drug, is both a depressant and a stimulant, depending on the user and the environment. Tom, a middle-class worker likes to get high to escape daily pressures. His dealer persuades him to try something called superweed. At home, after dinner, Tom smokes a cigar laced with PCP. He becomes violent and assaults his wife. A counsellor, a former user, explains how dangerous the drug can be.
General evaluation: Poor (2.0). This film is out-of-date, and the information no longer useful.
Recommended use: Archival.

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Hospitals Meeting the Challenge of Alcohol and Drug Problems — March 5, Toronto, Ontario. Information: Gwen MacKinnon, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Relaxation and Stress Management Workshop — March 5-6, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

1987 Health Care Management Conference — March 11-13, Toronto, Ontario. Information: Ingrid Norrish or Karen Tavener, Conference and Seminar Services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

The Community and Northern Justice — March 15-20, Whitehorse, Yukon. Information: Northern conference office, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Suicidal Behavior in Children — March 20, Windsor, Ontario. Information: Antoon A. Leenaars, suicide prevention/awareness committee, Dept of Psychology, University of Windsor, 401 Sunset Ave, Windsor. ON N9B 3P4.

Seminar for Scientists — April 2, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Behavioral Interventions Course — April 6-8, Toronto, Ontario. Information: School for Addiction Studies. Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Addictions Foundation Atlantic Conference 87 — April 26-30, Saint John, New Brunswick. Information: Roger A. Alain, information officer, Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, NB E3B 5H1.

1st Pacific Institute on Addictions — May 5-8, Langley, British Columbia. Information: Karl Burden, Alcohol and Drug Concerns Inc, 11 Progress Ave, Ste 200, Scarborough, Ontario M1P 4S7.

Prevention Congress III, Working Together to Build Healthy and Supportive Communities — May 6-8, Kitchener/Waterloo, Ontario. Information: Prevention Congress III, Lutherwood, RR 3, Waterloo, ON N2J 3Z4.

29th Annual Assembly of the College of Family Physicians of Canada — May 10-13, Halifax, Nova Scotia. Information: College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario M2K 2R9.

PRIDE Canada 3rd National Conference on Youth and Drugs — May 14-16, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

87th Annual Conference of the Canadian Lung Association — May 29-31, Montreal, Quebec. Information: Les McDonald, director, Health Education and Program Services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

Canadian Multidisciplinary Road Safety Conference and Annual Meeting of Canadian Association of Road Safety Professionals (CARSP) — June 1-3, Calgary, Alberta. Information: Madeleine Aldridge, conference coordinator, Faculty of Continuing Education, University of Calgary, 2500 University DR NW, Calgary, AB T2N 1N4.

Work and Well-being 87 — June 12-14, Edmonton, Alberta. Information: Canadian Mental Health Association, #200, 12120 - 106 Ave, Edmonton, AB T5N 0Z2.

Summer School for Addiction Studies — July 6-24, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1

28th Annual Institute on Addiction Studies — July 12-17, Hamilton, Ontario. Information: Betty Collins, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

United States

12th Annual Regional Institute on Alcohol and Drug Abuse — March 10-11, Belton, Texas. Information: Central Texas Council on Alcoholism and Drug Abuse, PO Box 203, Temple,TX 76503.

PRIDE 1987 International Conference on Drugs — March 19-21, Atlanta, Georgia. Information: Jean Alford, National Parents' Resource Institute for Drug Education, Inc, 100 Edgewood Dr, Ste 1216, Atlanta, GA.

5th National Symposium on the Impaired Nurse — March 25-27, Atlanta, Georgia. Information: National Nurses Society on Addictions, 2506 Gross Point Rd, Evanston, Illinois 60201.

American Society for Clinical Pharmacology and Therapeutics Annual Meeting — March 25-28, Orlando, Florida. Information: Elaine Galasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

American Orthopsychiatric Association Annual Meeting — March 25-29, Washington, DC. Information: Marion Langer, executive director, 19 W 44th St, Ste 1616, New York, NY 10036.

Chemical Dependency and Eating Disorders: Common Denominators and Differences — March 28, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

Western Conference on Addiction — April 2-4, Salt Lake City, Utah. Information: Charter Medical Corporation, addictive disease division, 11050 Crabapple, Rd, D-120, Roswell, Georgia 30075.

Southwest Conference on Wellness — April 23-25, Tempe, Arizona. Information: Diane C. Fausel, conference coordinator, Community Resource Associates, 8338 E Buena Terra Way, Scottsdale, AZ 85253.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism: Alcohol and Sports — April 23-26, Cleveland, Ohio. Information: Forum coordinator, NCA, 12 W 21st St, New York, NY 10010.

Biological Advances in the Treatment of Chemical Dependency — April 25, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

Northeastern Conference on Alcohol and Drug Dependence — May 3-6, Newport, Rhode Island. Information: Jane A. Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Road, Newport, RI 02840.

National Conference on Alcohol, Drugs and Women — May 3-6, Denver, Colorado. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St, Ste 181, Washington, DC 20001.

American Psychiatric Association Annual Meeting: Psychiatry in Medicine; Medicine in Psychiatry — May 9-14, Chicago, Illinois. Information: Cathy Earnest, APA, 1400 K St NW, Washington, DC 20005.

American Society of Hospital Pharmacists Annual Meeting — May 31-June 4, Washington, DC; Clinical meeting, Dec 6-10, Atlanta, Georgia. Information: Joseph Oddis, executive vice-president, 4630 Montgomery Ave, Bethesda, Maryland 20814.

4th Annual Summer Institute for Alcohol and Drug Studies — June 1-5, Evansville, Indiana. Information: Nadine Coudret, director, Institute for Alcohol and Drug Studies, University of Evansville, 1800 Lincoln Ave, Evansville, IN 47722.

3rd Annual National Rural Institute on Alcohol and Drug Abuse — June 7-11, Eau Claire, Wisconsin. Information: National Rural Institute on Alcohol and Drug Abuse, Arts and Sciences Outreach, University of Wisconsin, Eau Claire, WI 54702-4004.

Committee on Problems of Drug Dependence and the Research Society on Alcoholism, Joint Meeting — June 14-19, Philadelphia, Pennsylvania. Information: Martin W. Adler, Temple University, Dept. of Pharmacology, 3420 N Broad St, Philadelphia, PA 19140.

National Clergy Council on Alcoholism and Related Drug Problems Annual Meeting — June 15-19, St Augustine, Florida. Information. John O'Neill, executive director, 1200 Varnum St NE, Washington, DC 20017.

American Medical Association Annual Meeting — June 21-25, Chicago, Illinois; Dec 6-9, Atlanta, Georgia. Information: James H. Sammons, executive vice-president, 535 N Dearborn St, Chicago, IL 60610.

International Doctors in Alcoholics Anonymous Annual Meeting — July 30-Aug 7, Lexington, Kentucky. Information: L. K. Reed, secretary-treasurer, 1950 Volney Rd, Youngstown, Ohio.

Abroad

The International Congress for Alcoholism and Drug Abuse Counsellors — March 13-21, London, England. Information: Tom Claunch, PO Box 210638, Montgomery, Alabama 36121.

Annual Scottish School on Alcohol Related Problems — March 23-27, Edinburgh, Scotland. Information: Jean Nevay, Scottish Council on Alcohol, 147 Blythwood St, Glasgow G2 4EN, Scotland.

7th International Conference on Alcohol Problems — April 5-10, Liverpool, England. Information: Conference secretary, 1st fl, The Fruit Exchange, Victoria St, Liverpool, L2 6QU England.

International Symposium: Medical Education and Alcoholism — April 20-23, Santiago, Chile. Information: Alfredo Pemjean, Universidad de Chile, Facultad de Medicina, División Ciencias Médicas sur Proyecto: Educación Médica y Alcoholismo Correo 10-D, San Miguel, Santiago, Chile.

3rd Annual International Industrial Alcoholism Symposium — May 25-27, Frankfurt, West Germany. Information: Sara Bilik, symposium chairperson, Conecta Partners, Berger Strasse 211, 6000 Frankfurt 60 FRG, West Germany.

16th International Institute on the Prevention and Treatment of Drug Dependence and the 33rd International Institute on the Prevention and Treatment of Alcoholism — May 31-June 5, Lausanne, Switzerland. Information: International Council on Alcohol and Addictions, Case postale 189, 1001 Lausanne, Switzerland.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

International Conference on Alcohol-related Problems at the Workplace — Sept 27-Oct 1, Newcastle-upon-Tyne, Great Britain. Information: Peter Rørstad, director, North-East Council on Addictions, 1, Moseley St, Newcastle-upon-Tyne, NE1 1YE, Great Britain.

The Journal

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Drug addicts, acupuncture, and retraining

Acupuncture has been used by treatment workers to help drug addicts for approximately 13 years. The Journal ***first published a report on the procedure (see clippings below) in March, 1978.***

Today, clinics in Great Britain and Hungary, as well as across the United States, consider acupuncture a regular treatment modality.

And, one clinic in Los Angeles has added an economic alternatives model to its use of acupuncture, with support groups, in a drop-in, detoxification setting, hoping to reduce crime in the downtown core. Correspondent Connie Zweig ***reports.***

LOS ANGELES — A drop-in, detoxification centre in the downtown skid row area here is treating both drug addicts and those addicted to nicotine and caffeine through acupuncture.

The Turnaround Alternative Treatment Center, a non-profit affiliate of the Crime Prevention Through Substance Abuse Treatment organization, was started by volunteers from the sheriff's department, the Los Angeles Police Department (LAPD), downtown social agencies, the medical community, and the business community — diverse groups with a single focus: reducing urban crime by reducing drug abuse.

At the clinic's official opening in January, Los Angeles County Supervisor Edmund Edelman said: "We estimate 90% of all crimes are committed by drug-addicted people. If this program works, we could duplicate it throughout the county."

Retired LAPD captain Diane Harber spearheaded the project for precisely the same reason: "A high percentage of crime is committed by people seeking money to buy drugs. If we can stem this tide, we should begin to see a big reduction in crime and all of its economic consequences."

Municipal Court Judge Charles Rubin, a member of Turnaround's steering committee, concurs: "The courts are backed up with criminal cases in which drugs and alcohol play a significant role."

Ms Harber said she was frustrated with the revolving door of arresting drug users and sending them back out on the streets.

"And, I hadn't seen a treatment program in existence that had had a great deal of success with hard-core addicts."

Then she learned about a New York city treatment centre using acupuncture to treat addiction (**The Journal**, January 1981); she went to see how it worked. Pioneered by psychiatrist Michael Smith, PhD, at Lincoln Hospital in the South Bronx, the program has achieved good results for 13 years with hard-core addicts.

Counselling too

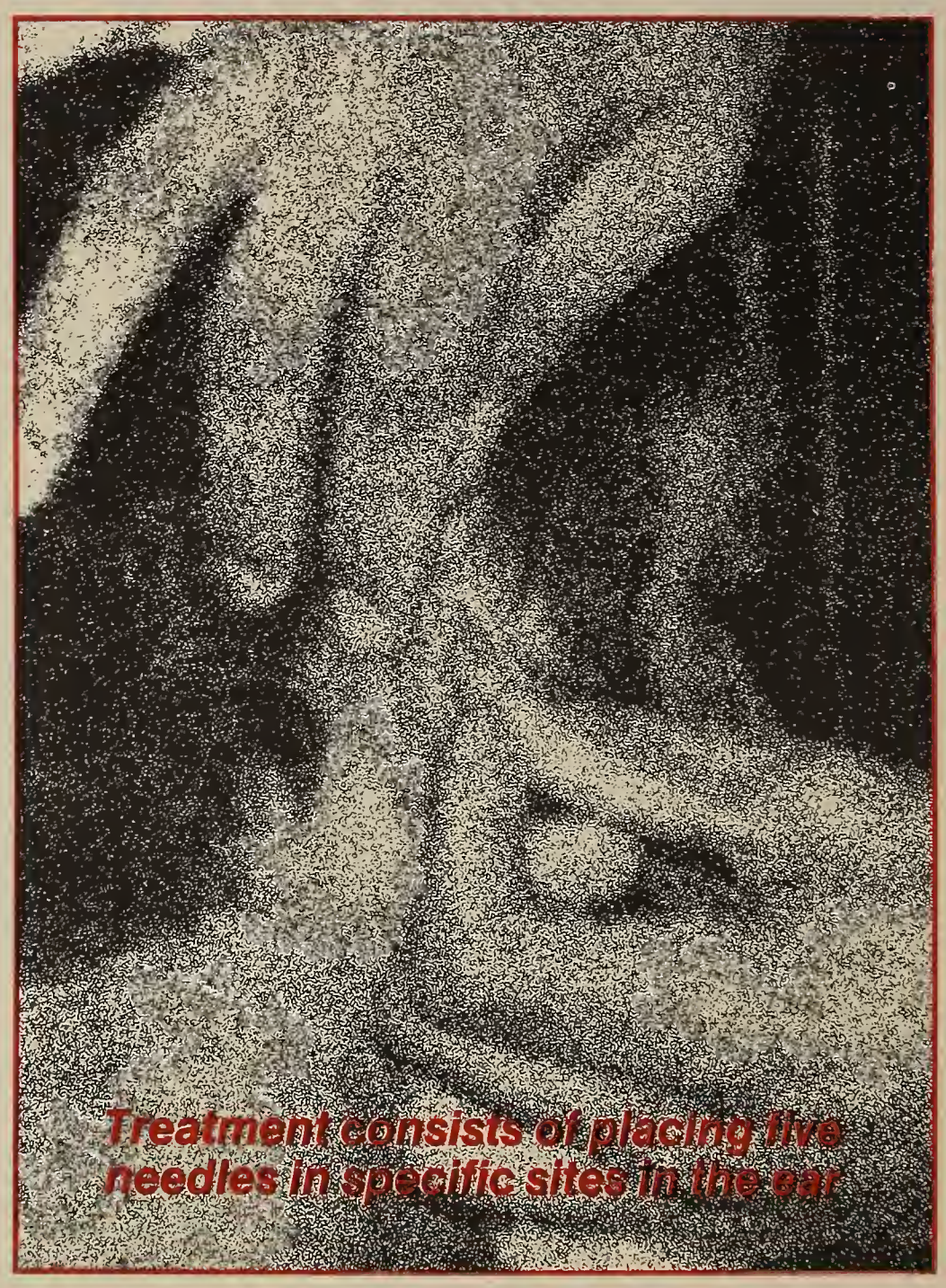
"We were using methadone to treat heroin addicts when we read reports of a doctor in Hong Kong using acupuncture," Dr Smith told **The Journal**.

At first, Dr Smith used acupuncture in conjunction with counselling for 20-year alcoholics referred by the Welfare Department. A survey showed 28% of them had stopped drinking.

The acupuncture program was then used, in combination with Alcoholics Anonymous and Narcotics Anonymous, to treat cocaine and heroin addicts. The result: a 40% to 50% success rate.

"Acupuncture alone is not sufficient," Dr Smith reports. "It depends on a combination of treatments. But in the first month, it works far better than any other mode of outpatient treatment that exists.

"If people are to stay clean for years, they need to look at their lifestyles on an ongoing basis."



Treatment consists of placing five needles in specific sites in the ear

Today, clinics in Boston, Massachusetts; Washington, DC; Albuquerque, New Mexico; Minneapolis, Minnesota; San Francisco, California; Portland, Oregon; two United States Native reservations, Great Britain, and Hungary use Dr Smith's centre as a model.

To launch Turnaround here, Ms Harber recruited Bruce Monroe, a sheriff's department planner, who volunteers as the project's steering committee chairman and director. Mr Monroe found backing through a small grant from the California Community Foundation and thousands of dollars in goods and services from local businesses. The city donated the site on San Pedro Street.

Mr Monroe designed a three-tiered program: acupuncture, support groups, and economic alternatives.

Mr Monroe: "This is the first program in Los Angeles County to address alcohol and drug problems in the context of medical, social, and economic development, which are all necessary for successful, permanent recovery."

Turnaround's pilot program has been underway at the SAMRA School of Acupuncture in the Westlake District for three months. A satellite clinic treats addictions free of charge from 7 am to 10 am Monday through Saturday, while the San Pedro centre charges on a sliding scale. Turnaround also has a Los Angeles hotline, 623-HELP.

Turnaround's staff has treated several hundred patients, including Albert, 28, who had a $400-per-day heroin habit for eight years before he began treatments at Turnaround: "I went in pretty sick, but decided to go cold turkey after the first treatment. Now, the cravings are down, and I can think straight and sleep okay. Before, all I could think of was a fix."

Aubrey McCoy, 39, a writer living in the Westlake District, is also a graduate of the program. He had smoked cigarettes since he was 19 years old and, until recently, hadn't gone without one for 24 hours. Today, he's a non-smoker and proud of it.

"If I had known it was so easy, I would have done it sooner," he said.

David Katzin, MD, of Los Angeles, a member of Turnaround's medical advisory board, is enthusiastic: "The early results are extremely encouraging and indicate acupuncture is an effective, non-toxic alternative to the use of methadone and other pharmacologic approaches to detoxification."

However, several outside experts point to possible shortcomings. P. Joseph Frawley, MD, chief of staff at Schick Shadel Hospital, Santa Barbara, California, where a combination of medical and behavioral approaches is used to treat addiction, questions long-term effectiveness.

"I've seen reports of acupuncture helping withdrawal," Dr Frawley said. "But, I haven't seen reports of any long-term recovery rates."

Larry Eckstein, MD, of Santa Monica, who uses acupuncture as part of his practice, said: "Long-term recovery must be based on multi-level interventions.

"Acupuncture needs to be supplemented with lifestyle intervention and commitment by the patient.

"I've had excellent results using acupuncture to reduce cigarette smoking, for instance. But, nothing can work unless the patient really wants it."

Basil Clyman, MD, associate chief of staff for ambulatory care at the Veteran's Administration Hospital in Sepulveda, was formerly in charge of a detoxification service for Los Angeles County and University of Southern California.

"It's important not to lose sight of potential medical complications that can come with drug addiction and withdrawal.

"If the stress of withdrawal is added to medical problems like ulcers, trauma, or infection, it can exacerbate the problem and make patients more ill," he said.

"Those who use alternative techniques tend to get over-focused on their own treatment modalities and overlook other problems. Acupuncture can do no harm, provided it's done with medical observation."

The Turnaround treatment consists of placing five needles in specific sites in each ear of the patient, every day for about two weeks (**The Journal**, May, 1983).

Gary Archer, an acupuncturist at SAMRA, explains: "In Chinese medicine, the ear is a microcosm of the whole body, so we can treat any organ by treating the ear.

"Drugs deplete the body's energy, but acupuncture helps clients maintain their energy. It eases the whole process so they can cope with the anxiety and other physical problems during drug withdrawal."

Self-support

Steve Wolf, a psychotherapist in private practice in West Los Angeles, is training counsellors to organize mutual, self-support groups for those trying to kick their habits.

"We realize that we're attempting the impossible," he said.

"These people have a 24-hour-a-day habit, and they come here for one hour that's different. In standard treatment, they would be locked away from their normal lives, cut off from external contact, to break their patterns. But, even those programs have only a 30% to 40% success rate."

Mr Wolf designed a social support system to help people deal with the emotional issues that come up during withdrawal.

"Clients learn to recognize their early warning signs that precede the desire for a substance. They learn to make an internal connection by using their own breath to ease the craving. And, they can break their patterns of social isolation by creating friendships with others who take personal responsibility for their addictions.

"Acupuncturists say every symptom is an imbalance of the whole system.

"We see people's addictions as symptoms of their social environment. They need to develop new identities, new life plans, and that is the aim of the self-support groups."

Besides crisis intervention, counsellors refer clients to other community agencies and resources here.

"We don't want to duplicate other services already available," Mr Wolf said.

Successful graduates of the program are expected to try new business ventures.

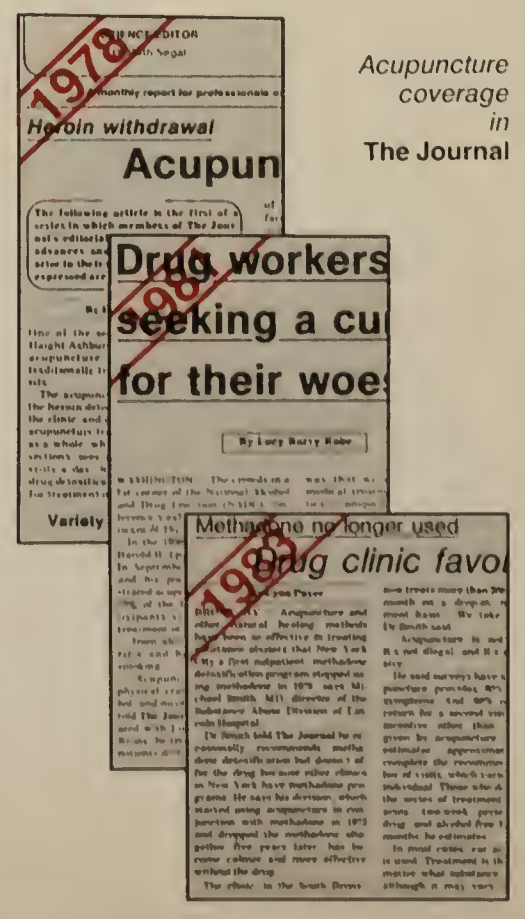
"We're planning to set up a pipeline of activities through which people can pass back into society," explained Buddy Nadler, chairman of the business committee.

"Projects begin simply and in a variety of forms." For example, a local janitorial service offers training and jobs, and a community beautification project includes instruction in carpentry and other building skills.

Mr Nadler: "The key idea is labor entrepreneurs, people who will develop businesses and become part-owners in them. These enterprises will be rooted in the relationships that are built in the self-help groups."

"We know that acupuncture can detox them," Mr Wolf said. "But they are only declared clean by most experts after 18 months.

"So acupuncture is only the first step. That's why we're designing more into the program — an effort at real transformation, real healing."



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The Journal

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AIDS issues permeate drug field

'As little as we know, we can't afford not to take positions'

By Harvey McConnell

FORT LAUDERDALE, Florida — Concerted political action is the only way to prevent the AIDS disaster from steamrolling the chemical dependency field.

The field in the United States and elsewhere will be radically altered: from research through treatment to confidentiality.

"AIDS is a major threat to our entire field: an epidemic with potentially disastrous proportions which clearly is having and will continue to have global as well as national implications," declared Robert Niven, MD, former director of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) and now director of the chemical dependency program at Harper Hospital, Detroit, Michigan.

Not only will everyone in the field be affected, but also the entire focus of medicine will be overhauled.

"AIDS is a public policy disease," said Dr Niven. He can think of no other disease "that is going to affect more broadly all segments of society and in which the public will get more involved in decision making."

Before going to Washington to head the NIAAA, Dr Niven said he didn't much like politics; in some ways he still doesn't.

"But, I have become convinced you have to make the political process work for you if you really want to have the best chance of getting the outcome you want. Not to get actively involved now is simply unacceptable."

Dr Niven outlined a number of assumptions and predictions in an address to a conference on AIDS and Chemical Dependency held here by the American Medical Society on Alcoholism and Other Drug Dependencies.

In the past, and over time, one could take positions based on a reasonable degree of scientific precision. AIDS is different: "We can't wait. As little as we know, we can't afford not to take positions and actions."

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Dr Niven made four major assumptions:

- there will not be a major breakthrough in treatment for people with AIDS in the next five years. There will be advances, but these will not be revolutionary;
- most people are well-intentioned at a conscious level and do not set out to get the disease. But, people have fairly healthy drives, particularly in the sexual area, and while behavior may change, drives won't decline to zero;
- many people are frightened, whether because of a lack of knowledge, failure to think about it, or denial; and,
- people will change their behavior. Many may disagree "but I am an optimist."

Dr Niven said the impact of AIDS will mean increased focus on: patients treated for alcohol and other drug problems, all diseases with a behavioral component, methods used to treat alcoholic and addicted patients, treatment outcome, eligibility for treatment programs, and the length and cost of treatment.

Above all, while most people think AIDS patients should receive care and treatment, costs will be prodigious as the number of cases inexorably rises.

There must be increased focus on research, and, if the chemical dependency field "plans carefully and assertively, there will be chances to enhance funding for alcohol and drug research." But if the field does not play its hand carefully, the chances for funding

(See Routine, p2)

Recuperating from assassin's bullets

Colombian diplomat battles on

By Anne MacLennan

VIENNA — His jaw still wired closed following bullet-removal surgery in the aftermath of an attempt on his life, a Colombian diplomat told **The Journal** here: moral commitment is more important than money in crippling international drug syndicates.

Urging every citizen of every country to become a fighter against drug crime, Enrique Parejo Gonzalez spoke with **The Journal** only weeks after he was hit by a spray of bullets fired at him by a lone gunman on the streets of Budapest.

A South American "drug commando unit" claimed responsibility for the January 13 shooting.

Until August, 1986, Mr Parejo was Colombia's minister of justice, a post he had assumed in 1984 after the assassination of Rodrigo Lara Bonilla, another campaigner against drug trafficking.

In the post, Mr Parejo started a daring campaign against trafficking and for the eradication of illicit cultivation, receiving frequent threats to his life in the process.

As minister, he approved the extradition of Carlos Lehder Rivas to the United States.

Carlos Lehder Rivas, accused of being one of the great cocaine barons of his country, is now awaiting trial in the US.

In August, 1986, after a change of administration in Colombia, Mr Parejo was appointed his country's ambassador to Hungary, one of the eastern bloc countries to which some Colombian justice officials are said to have been posted to protect them from the wrath of narco-terrorists (**The Journal**, February). Many Colombian officials have been killed by them.

That Mr Parejo was shot in Budapest — across the world, and months after he was removed from his country — is seen by many as a reflection of the life and death power, and the reach, of drug syndicates — even into cities and countries far removed from areas usually considered drug trouble-spots.

Eve Koudn Kuhn

Parejo: moral power

On February 2, this year, closely protected by a squad of bodyguards wherever he moved, Mr Parejo took up his seat here as chairman of the Commission on Narcotic Drugs, a meeting of hundreds of people from around the world. At the end of week two, he began a week as chairman of the preparatory body for the June International Conference on Drug Abuse and Illicit Trafficking (ICDAIT (**The Journal**, March).

In an interview, and as his bodyguards stood outside the door, he told **The Journal**:

"I am now convinced that different countries now have clearly seen it is impossible to fight in an isolated way. They have to make efforts in a consolidated way. Otherwise, it will be impossible. And, the fight must be integrated, at every level; narco-trafficking must be attacked in the field of production, in the field of illicit traffic, and in the field of demand.

"The job countries have in front of them is not easy — precisely because of the immense power of the narco-traffickers. But, I am sure that if all countries involved in the problem fight against the criminal organizations of traffickers, it is possible to defeat them.

"But, it is necessary that the effort be linked between countries. What we are doing now (at the Commission and preparatory meetings) and what ought to be done during the international conference of ministers (ICDAIT) is to tie the efforts of all countries to-

(See Colombian, p2)

Hospitals broaden net to catch addicts

By Terri Etherington

TORONTO — A multidisciplinary, public health approach is the best way to reach the 20% to 30% of the general-hospital patient population with addictions, who remain undiagnosed and untreated.

These patients are on every ward, every day. But, unless their alcohol and other drug problems are noticed by busy hospital staff and dealt with, they become part of the health system's revolving door, returning again and again for related health problems.

Representatives from hospitals across Ontario, here at a one-day conference sponsored by Ontario's Addiction Research Foundation (ARF), explored ways to become part of the solution, instead of part of the problem.

James Rankin, MD, ARF head of medicine and conference chairman, said hospitals should look at ways to supplement or complement existing services in the community.

Evelyn Kent, director of planning and research, Metropolitan Toronto District Health Council, said addictions knowledge in hospitals, at all levels, will aid in developing a continuum of care.

"When you look at people in trouble in a place like Metro Toronto —

(See Primary, p6)

INSIDE

NEWS

Briefly . . .

A shunning star

TORONTO — *The Toronto Star*, Canada's largest circulation daily newspaper, is no longer accepting tobacco advertising, reports *Marketing*. The decision, covering both the newspaper and its *Starweek* television guide, will not affect publication of announcement ads for sports and other events sponsored by tobacco firms. Co-op or third-party advertising, which might include tobacco items, will also not be affected.

What's not hot

LANSING, Michigan — Great Expectations, a national video dating service club in the United States, says drinking and casual affairs are out and caution and commitment are in. The club came to this conclusion following a representative study of its 40,000 members, says *Monday Morning Report*.

Plane gets sheared

MOSCOW — Drunk crop dusters, hungry for mutton, illegally took off in a plane in search of sheep and crashed, killing six of seven men aboard, the newspaper *Vozdushny Transport* has reported. It said the last words of the second pilot were: "What have we done?"

Smokerlyser?

LONDON — A heavy smoker will be able to see what she is doing to her body with the help of a Smokerlyser. The testing device is to tobacco what breath testers are to alcohol, reports *The Medical Post*. The instrument indicates, in figures, the amount of carbon monoxide in a smoker's lungs, and colored lights and clicking noises maximize the overall effect.

Needle trade-in

LONDON — The British government is setting up a pilot program to provide free hypodermic needles to drug addicts as a method to help stem the spread of AIDS. Addicts will probably be able to exchange their needles for sterile ones at treatment centres in 12 cities with major drug problems, says *Medical World News*.

For peat's sake

STORNOWAY, Scotland — After 45 years, the island of Eriskay has run out of free scotch, reports *Associated Press*. Island resident Allan Macdonald is seeking permission to open a pub — The Politician — in memory of a ship that sank off the island in 1941, dumping 20,300 cases of whisky. Police then were unable to stop looting, and because there was plenty, women were seen using the whisky to help their peat fires burn more easily.

Happy ending

EDMONTON — The Alberta Hotel Association is pressuring the provincial government to end happy hours. Executive vice-president Jim Hanson told *Canadian Press* happy hours are expensive for hotel owners and the only people who benefit are patrons and the provincial government, which collects taxes on the extra alcohol consumed.

US student survey: only 4% use crack

WASHINGTON — Overall drug use among United States high school seniors continues to drop except for cocaine, the latest survey by Lloyd Johnston, PhD, and colleagues at the University of Michigan indicates.

The survey conducted for the US National Institute on Drug Abuse found 17% of seniors had tried cocaine, 13% had used in the previous year, and 6% had used in the previous month. However, Dr Johnston notes the survey, among 1986 graduates, was completed before the highly publicized deaths of sport stars Len Bias and Don Rogers.

The 12th annual study in nearly 130 high schools (**The Journal**, December, 1986) found the number of seniors experimenting with any illicit drug fell to 58% in 1986 from 61% in 1985. This still makes such drug use high compared with other industrialized nations.

Twenty-three percent of seniors reported marijuana use during the past month, down from the peak of 37% in 1978.

Similarily, reported daily marijuana use declined to 4% in 1986 from 11% in 1978.

Dr Johnston and colleagues, for the first time, reported on the use of crack: 4% of the seniors reported using it at least once in the previous year, with most use concentrated in students not bound for college. Dr Johnston said it appears the rapid spread of public information about the dangers of crack has moderated its rate of increase.

Routine AIDS-screens likely: Niven

(from page 1)

of traditional alcohol and other drug research will diminish, Dr Niven predicted.

Religion cannot be excluded from the discussion, because of a probable increased prevalence of AIDS among the clergy. "And, because of the inextricable link between sexual behaviors and morality, a major review of a lot of strongly held religious beliefs will be forced. Position statements from the churches could indirectly impact on treatment programs."

Attempts to prevent people applying for insurance from being tested for the AIDS (HIV) antibody will not work, Dr Niven suggested. Private insurance has nothing to do with health; it is about making money, and companies will simply stop writing policies if they cannot assess risks.

Ethical issues are myriad: the rights of patients with AIDS, or high risk of AIDS, and the rights of other people; the rights of the individual vs the rights of society; the rights of patients to be diagnosed or not; and, the rights of patients to get treatment or not.

Confidentiality and privacy are becoming less important issues as they are being resolved on practical levels because of the rights of society, fellow patients in treatment, children, and sexual consorts.

Screening for presence of the HIV antibody is extremely controversial, but Dr Niven has no doubt that for high-risk groups, the screening is appropriate and beneficial. "Regardless of whether you agree, I will say to you it is inevitable.

"In my view, by 1991 (by which time the number of AIDS cases in the US is expected to increase 10-fold from the present 30,000), people who enter hospital will be screened in almost every age group. In a few years, screening will be very commonplace. I will go further: by 1991, many people in the health-care field will be screened, and some of them will be prohibited from working in various aspects of the field if they are antibody positive.

"All of this is controversial and debatable, but I think it is going to happen."

Polls show a majority of people favor screening for the HIV antibody. For this reason, as well as for medical, legal, and cost reasons, screening is going to become common. Dr Niven also forecasts there will be a plethora of ripoffs, such as one he knows of which offers a twice-yearly blood test and a pin signifying you are HIV negative — all for $300 a year.

And, in the baggage train will come the lawyers: "There are going to be fewer underemployed lawyers; they are going to make a lot of money."

Lawsuits will be filed: against condom manufacturers, claiming the condom broke while in use; that those with the HIV antibody were not appropriately diagnosed and treated; and, that partners of people with AIDS or the HIV antibody were not warned.

"This is going to happen really fast. Regardless of what the confidentiality statutes are, they will not prevent lawsuits."

Dr Niven said there will probably be a resurgence in methadone maintenance programs. It may be a worthwhile strategy in the short-term in the US to try to get intravenous (IV) drug users into what he calls "a smart-user approach" to minimize their risk from IV drug use if they cannot remain abstinent.

Dr Niven expects there will be distribution of sterile needles. "Many pharmacists are quite prepared to distribute sterile needles: all they need is for someone in authority to say it is okay."

Dr Niven suggests the easiest question to answer — with only a minor qualification — is whether people with AIDS should be treated for chemical dependency. He says yes, and the qualification is that some people with AIDS will not want treatment. Given their short life expectancy with the disease, for practical and humanitarian reasons there may be some who will be better off left to their own alcohol- or other drug-using devices.

Treatment of AIDS patients with chemical dependency should borrow from both regular and specialized programs. "I think treating those with AIDS, or those who are sero-positive, in the context of a short, inpatient program really runs the risk of not doing either very well. It is a tough issue that needs to be addressed."

Dr Niven recommends: that everyone in the chemical dependency field become involved in a major way in the issues; that routine screening of high-risk groups should and will be implemented; and, that all programs have a prevention and education component about how to reduce the risks of being infected with the HIV antibody.

Issues should be tackled aggressively, openly, comprehensively, and with sensitivity to individual issues. The emphasis should be on risk groups, not alcohol or other drug users or homosexuals. Dr Niven said the high-road approach should be taken, avoiding defensive pitfalls such as issues of homophobia or whether an IV drug user brought the condition on himself.

Niven: myriad issues

Colombian traffickers strike out

(from page 1)

gether," said Mr Parejo.

He continued: "All the money we can spend to fight against drugs at this moment, is less than what is necessary. But, I insist that most important is to create a conscience about the importance of the fight in all societies. I think it is more important to have a moral commitment, moral power, than the economical resources.

"We have to make of each citizen a fighter. It is not an easy job, but it is necessary to do it."

He said damage of trafficking is not only to the economies of countries. "You also have to remember the lives — the very, very valuable lives — that countries have lost because of assassination by narco-traffickers."

On a question about proposals by narcotic traffickers that they could assist Colombia in eradicating its national debt, Mr Parejo said:

"There is not any possibility that the government of Colombia can talk with narcotic drug traffickers. When I was minister of justice, the government received a paper where the narco-traffickers said more or less that same thing.

"But, I had, on that occasion, the opportunity to refuse in the most energetic way that pretension of traffickers."

Framingham data are used to link stroke with smoking

TAMPA — A definitive link between cigarette smoking and the risk of stroke has been established with data from a famous, long-term, United States heart study.

The information presented by Philip Wolf, MD, a neurologist at Boston University School of Medicine, utilizes data from the Framingham heart study. It helps confirm an association long-suspected but only shown for the first time in the Honolulu heart study. Those study results, published last fall, dealt only with Japanese men living in Hawaii.

"Now, we have enough cases, we've followed them long enough, and we're able to analyze it (the data) appropriately. There's no question cigarette smoking is related to stroke," Dr Wolf explained prior to the American Heart Association annual conference on stroke and cerebral circulation here.

"It's true in both men and women, it's true at all ages, and it's related to the amount you smoke."

The good news for smokers is that within two to five years of quitting, former smokers have no greater risk of having a stroke than do lifetime non-smokers.

The study population involved 4,255 people enrolled in the Framingham heart study in 1955, who were stroke-free and between 36 and 68 years old at that time. They were followed up during the next 26 years. In that period, 459 sustained a stroke.

A raw comparison of the smokers and non-smokers in the group showed men or women who smoked had a 20% to 30% greater chance of having a stroke. When quitting was taken into account, current smokers were found to be even more at risk of sustaining a stroke or brain infarction than non-smokers.

The risk was directly correlated with the amount smoked, and both men and women smokers of more than 40 cigarettes daily had a 90% or greater risk of stroke than non-smokers. Smokers of 10 cigarettes-a-day had 17% to 19% greater risk.

The relationship between smoking and stroke or brain infarction remained even when other major cardiovascular risk factors — weight, cholesterol levels, and glucose intolerance — were taken into account.

Dr Wolf said hypertension is perhaps a more powerful risk factor than smoking for stroke, but added, "The message is you want to make everybody a normotensive, non-smoker."

NEWS

Stamler voices widespread concern

Official corruption key to drug trade

By Anne MacLennan

VIENNA — Corruption of law enforcement and judicial authorities is one of the major problems in eradicating drug trafficking, says Rodney T. Stamler, chief of the Drug Enforcement Directorate, Royal Canadian Mounted Police (RCMP).

"The problem starts in the countries where production is allowed to continue — because of corruption.

"The product is available because of corruption, and the organized crime base continues because of corruption," he told **The Journal** here.

He said at its core, the problem is the income of police officers in the face of the potential wealth of criminals.

"There's no question that when police are poorly paid and criminals have a lot of money, you're going to have corruption automatically. It's almost an accepted situation."

(Although corruption is taken as a given by most national and international authorities in the field, it is rarely addressed formally or publicly. For many years, Peter Lee, a former commissioner of narcotic drugs for Hong Kong, was the lone voice on the subject at the United Nations Commission on Narcotic Drugs, the international drug parliament.)

Chief Superintendent Stamler (see page 7)said: "I don't think there's much in Canada. What happens in Canada is the delivery to traffickers. I think we're fortunate that we have virtually eliminated major organized crime groups from monopolizing trafficking.

"But, the problem is that we have so many groups operating and extending out to other countries where there is a large organized crime base that we virtually have to take down the organized crime base in that other country to make a dent on the Canadian scene."

He said what makes Canada less vulnerable to police corruption, is "first of all, we have a lot of different authorities involved in enforcement in the same territory. We don't have one territory that belongs exclusively to one jurisdiction."

Also, he said, "we use informants a great deal. We listen to them. Many countries don't, and many condemn their use.

"But, I think it's a fair system. We need proactive police activity in consensual crime areas.

"In other words, if everybody's consenting to the crime, how are the police going to detect the crime was being committed at the higher levels without having the assistance of a co-conspirator, without an informant, or without including surveillance by undercover operators who infiltrate the groups — whether it's electronic surveillance or surveillance by undercover operators?"

Crack problem skips Toronto — so far

By Peter Unwin

TORONTO — So far, this large, Canadian city has escaped the crack problems seen in some major North American centres (**The Journal**, August, 1986).

However, police authorities are concerned the potential for trouble is here.

"We should be ready," Sergeant Craig Hilborn of Metropolitan Toronto Police's Central Drug Information Unit, told **The Journal**.

"There are large amounts of cocaine around; it may just happen. Fortunately, as of yet, it hasn't."

Toronto cocaine seizures do not include seizures made by the Royal Canadian Mounted Police (RCMP).

Robert Fahlman, officer in charge of the Strategic Intelligence and Publications Branch of the RCMP's Drug Enforcement Directorate in Ottawa, says large amounts of cocaine are seized at the Canadian border.

"But, little of it is crack. What little crack is found seems to be for personal use in the gram to one ounce range."

Although 1986 cocaine seizures in Toronto were up by 90% from the previous year, the increase should be interpreted in light of increased police activity.

Sgt Hilborn: "We are definitely paying more attention to cocaine investigations now. The specific drug squads are gearing in on it."

Marijuana seizures for the same time went down drastically as police priority shifted to cocaine.

"Marijuana seizures were down 181%," says Sgt Hilborn. "But, that doesn't tell me there's less marijuana out there."

Hung-over pilots miscue on maneuvers

By Harvey McConnell

WASHINGTON — Significant effects on performance 14 hours after drinking were found in 10 experienced, United States Navy pilots by researchers at Stanford University School of Medicine, Stanford, California.

Hangover effects were similar to those found in an earlier study among private pilots tested 24 hours after smoking marijuana cigarettes (**The Journal**, February, 1986), researcher Otto Von Leirer, PhD, told a science press seminar here, sponsored by the US Alcohol, Drug Abuse and Mental Health Administration.

Dr Leirer and colleagues will study older commercial pilots in the next three years to see if hangover effects of alcohol in similar situations are more pronounced and last longer.

The navy pilots studied were less than 32 years old and in superb physical shape — "these guys are going to live to be 120." They regularly flew missions over the Pacific Ocean hunting submarines in four-engine, PC-3 Orion turbo prop planes, from Moffett Naval Air Station in California. All were social drinkers, with use varying from an average of two drinks a week to an average of two drinks a day.

In the study, the pilots were tested twice through simulated flights: once after abstaining from alcohol for at least 48 hours, and once 14 hours after they had drunk enough alcohol mixed with soda pop to reach a 0.10% blood alcohol concentration (BAC). By the time the 14-hour deadline had been reached, their BACs had returned to zero.

The study flights included take-offs, short flights, and landings on a complex simulator to test the pilots' abilities to perform crucial maneuvers. Two engines on the left — or the right — side of the plane failed during take-off or landing, for example: "(This is) the pilot's nightmare, which puts him in a very tough situation and forces him to perform at peak ability," explained Dr Leirer.

In the hangover sessions, the pilots performed significantly worse on virtually all measures. There were significant increases in yawing (the plane twisting sideways), and, on landings, there were significant variances in correct headings and rates of descent.

There was no correlation between pilots' experience and subjective measure of performance and the researchers' objective measure of performance. Some pilots felt they had a hangover, and some did not. And, "there was no relationship between how they felt and how they performed," said Dr Leirer.

The researchers found many of the pilots didn't realize when they were legally intoxicated.

Dr Leirer said effects of alcohol on sleep patterns after drinking might have a profound effect on reactions, especially when there are emergency conditions. He noted: "Any reduced ability to fly an aircraft — no matter how small — increases the probability of a serious accident. That increase may be very small, but, at the same time, there are hundreds of thousands of flights in the world every day."

INSIDE OUT

Changing public perceptions

We were on a boat, getting ready to sail out into the harbor, on a spitting-rain-filled evening at the end of the season.

There were six of us, and the conversation was going easily as we drifted away from the dock, although my friend and I had not met two of the others on board before.

We ate our sandwiches out on the deck, pulling the plastic gear up over our heads — the rain was starting to get a little stronger — and the hostess asked us what we'd like to drink.

It was all so perfect; even the rain added to the peacefulness. There was the city, spread out in a strange, grey-gold necklace behind us. And there were the other boats bobbing all around on the lake, looking so pretty in their fragility, sails puffing proudly. Their different colors dotted the eyes like so many waving handkerchiefs at a World War II train station.

And here we were, six decent, successful people, bright and amusing, you'd say, and determined to enjoy and entertain one another. We'd sailed off for a few hours into the playful oblivion found in innocent, watery joys, glad to be away from the traffic fumes, knowing this was probably the last time to be out here this year, just like this, before the snows and wicked winds got down to their nasty business.

The others gave their preferences to the hostess; when she got around to me she asked, "Orange juice? Soda? Coke?"

A soda would be fine, I said. One of the two people I'd not known before the voyage began looking at me and asked if I was on the wagon.

He was a burly man, eager and bearish, the kind of guy advertising account executives seek for beer commercials. I could tell from the look in his friendly eyes that he was wondering why I'd come along for the trip if I wasn't going to be drinking. Was I going to prove to be a drag? Because drinking was what you did, of course, out here on the water, away from responsibilities — wasn't it?

I thought of all the famous people coming out publicly about their addictions

"Yes, I'm on the wagon," I told him, ready to take out one of the stock quips from my quiver of drinking jokes, in case he asked me why or for how long.

"How long?" he asked.

"Oh, almost two years now," I told him.

He seemed both impressed and suddenly uneasy.

"Two years? Two YEARS?"

He shook his head. Then he was silent and even more uneasy, but a little less impressed somehow.

"How come? I mean, have you found religion?" he joked. "You're not one of those born-agains, are you?" He looked at the hostess.

"No. I'm an alcoholic."

I said it coolly, deadpan, with the emotional weight I would give if you asked me the name of the street I live on these days.

But, it was as if I'd suddenly hit him with a sucker punch while we were being introduced at a civilized cocktail party.

And, I was surprised by my quick answer too; I had never told anyone, let alone a stranger, just exactly what I was, with such bluntness — with no explanations, no evasions. Even people I'd known for years got the full treatment, if I could sense any genuine curiosity, when the subject of my drinking came up.

They heard the epic details; they listened, often somewhat raptly, if I was feeling inspired, or sometimes with polite indifference, if I was feeling bored by the topic. Usually there were follow-up questions, and detours, because most of my acquaintances and friends — hell, just about all of my friends — are hard-drinking types. It goes with the territory of our lives.

The burly man didn't know what to say. He was looking, I could tell, for some sort of adequate rejoinder for me. He was also looking for me to expand on what I'd just said. He was looking at the other people on the boat too, the host and hostess, who knew me well, and, most of all, the guest he'd come with and the woman I'd invited.

But it was a closed subject, like the rain that now ended.

I suddenly knew I didn't want to talk about it, and the voyage went on into the night. As I looked out over the calm water, it struck me that, from now on, whenever the subject of drinking came up again, in other circumstances with other strangers, I was going to say the same thing again, in the same way.

It felt so clean and good; there was such a finality to it, and I thought about all the famous people all over the world who were now coming out publicly about their drug and alcohol addictions, coming out in such numbers that it was all starting to become a bore, to tell the truth.

But it was better, I was beginning to think, as the sails ruffled in the breeze, than the way it used to be, back in the days of hiding the truth and shuffling the fictions into what passed for "facts" about the disaster that is addiction. Because, by hiding it, disguising it, distorting it, rearranging it, or lying about it, we magnify it. Yes, perhaps, we give it a too supreme importance; we let it become too great a ruler of our lives and minds. It becomes too gigantic to deal with concretely, practically, and without blinders.

Maybe, finally, we are changing our perceptions. Maybe, finally, we, who are stuck with addiction as a major fact of our beings, can admit it more easily, can stop denying the reality of our disease before that moment when it's too late and it just swamps us.

Maybe, one day, I mused on the boat, people will begin to admit, candidly and without embarrassment, that they have a problem before it's too late, before the damage is permanent. Maybe, their friends will do more to make them face it sooner, and they can say, "I think I'm an alcoholic," or "I am a drug addict," "I'm diabetic." And no one will blink an eye, and they can move, swiftly and fully, to deal with the problem and then get on with their lives again.

Or, is that just too fantastic a thought triggered by the sometimes deceptive calm of a sail on a lake, on a night full of magic?

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

RESEARCH

RESEARCH UPDATE

MDMA's complex effects

There is now hard evidence that MDMA (methylenedioxymethamphetamine) causes brain damage in rats. And, while researcher Christopher Schmidt from the Merrell Dow Research Institute in Cincinnati, Ohio is unwilling to extrapolate his results too readily to humans, he says his study shows there are toxicological grounds for concern about the widespread abuse of MDMA and related compounds. Following up earlier studies, Mr Schmidt reported on an investigation in which one milligram per kilogram doses of MDMA were injected to a group of rats who were then sacrificed and studied. He found in the cerebral cortex that the drug reduced concentrations of serotonin (a neurotransmitter) both shortly after administration and then a week later. These complex effects, he said, begin with a reversible depletion of transmitter in the acute stage but culminate in a permanent degeneration of the nerve terminal over the long-term. He says the parenteral doses used in the study are about four to eight times the human oral dose, but the effects were seen with a single administration of the drug. The possible cumulative effects of multiple MDMA exposures remain to be evaluated.

The Journal of Pharmacology and Experimental Therapeutics, January, 1987, v.240:1-8.

'Wet' prime time

Alcohol remains a major ingredient of prime-time television. A group of California researchers keeping watch on the appearance of alcohol in television programs since the mid-1970s has found that the frequency of scenes involving alcohol has risen to 74% from 62% in eight years prior to 1985. In the current study, researchers from the Pacific Institute for Research and Evaluation in Berkeley looked at 127 episodes of prime-time television programming, totalling 122.5 hours, picked at random from a two-week sample of programs from between 8 pm and 11 pm, in the 1984 fall season. Non-fiction programs were dropped from the evaluation; dramatic series and movies made up more than half of the final sample. All of the shows were watched by trained coders who recorded the number of 'alcohol appearances,' verbal or visual references to alcohol and drinking. "Alcohol is clearly a staple in the prime-time television diet," the study notes, with more than three-quarters of all episodes seen containing at least one alcohol reference. While characters drank alcohol in all four of the movies seen, the drug was seen in just more than half of the situation comedies. Overall, 60% of all programs in the sample showed at least one character drinking. While heavy drinking and drinking to drunkenness are seen rarely, the study concludes, the frequency of drinking on television "reflect(s) a 'wet' environment which exceeds that of the real world."

Journal of Studies on Alcohol, January, 1987, v.48:33-38.

Breathing abnormalities in pot smokers

Concurrent tobacco smoking doesn't appear to compound the many breathing abnormalities of long-time, heavy-use marijuana smokers. That's the conclusion of researchers from the schools of medicine and public health at the University of California, Los Angeles. To evaluate the pulmonary effects of marijuana smoking, the researchers gave a detailed questionnaire to and conducted lung function tests with: 144 young, habitual, heavy smokers of marijuana alone; 135 heavy users of marijuana and tobacco; 70 just-tobacco smokers; and, 97 non-smokers. Pulmonary function testing showed marijuana smokers had symptoms of acute and chronic bronchitis substantially and significantly more prevalent than the non-smokers. Concomitant tobacco use did not seem to have an additive effect on these subjects. Also, both marijuana and tobacco smokers had significantly more abnormalities in lung function than the non-smokers, with marijuana having more of an impact on the larger airways and tobacco smoking primarily affecting the peripheral airways and gas exchange. The researchers say they are unclear on the implications of their study as to subsequent development of chronic airflow obstruction in people who continue to be heavy users of marijuana.

American Review of Respiratory Diseases, January, 1987, v.135:209-216.

Pre-trial breath tests evaluated

An astonishingly high number of convicted impaired drivers arrived at scheduled, pre-sentencing, psychosocial evaluations with positive blood alcohol levels (BALs), a study conducted by researchers from the Community College of Philadelphia, Pennsylvania, shows. The researchers say their findings support the value of administering BAL tests at that time. In the study, a sample of 500 consecutive impaired drivers referred by the Philadelphia court system in late 1983 and early 1984 underwent breath tests prior to pre-sentencing evaluations. They were interviewed by a psychiatrist to determine whether they suffered from an alcoholism disorder. Breath analyses determined that 26.4% of the offenders had positive BALs at the time of their pre-sentencing interviews, and 8.3% had levels above 100 milligrams per millilitre. Evaluation shows those with positive BALs had higher BALs at the time of initial arrest and drank more than those without positive readings. Of 132 people with positive readings, 57% were diagnosed as having an alcoholism disorder; only 17% of those with negative readings were diagnosed as having such a disorder. The researchers conclude the results support the value of pre-trial breath tests for evaluating people arrested for drinking/driving offenses and for identifying those whose drinking behavior needs to be evaluated more fully.

Journal of Studies on Alcohol, November, 1986, v.47:500-502.

Pat Rich

Fetal cocaine exposure: coarse, anxious jitteryness

Mother's cocaine use identified through strands of newborn's hair

CARMEL, California — A few strands of a newborn's hair are all that is required to detect whether the mother has used cocaine during pregnancy.

An improved extraction method is responsible for the effectiveness of the new radioimmunoassay (RIAH), tested by researchers from the Childrens Hospital of Los Angeles, the University of Southern California School of Medicine, and the Wadsworth Division of the West Los Angeles Veterans Administration Center.

Researchers argue the new screening test could be more valuable than urine and serum toxic screens because the tests rely on recent exposure and may not detect exposure occuring prior to the immediate perinatal period.

Results of the investigation of the new test were reported here in a poster session at the annual meeting of the western section for Pediatric Research by Lance Parton, MD, a neonatology fellow.

To look at the efficacy of the new RIAH, the tests were done on infants up to three months of age, clinically suspected of being exposed to illicit drugs, or whose mothers gave a history of substance abuse.

All babies with positive urine tests for cocaine exposure had that exposure confirmed through RIAH. Drug exposure was also confirmed in one infant without a urine sample becausc of renal failure.

In one three-month-old infant, RIAH could not detect cocaine exposure even though the mother claimed she used the drug during her first trimester of pregnancy. For this reason, the researchers recommend the test results not be extrapolated to a period greater than 10 weeks prior to the time of analysis.

But overall, they conclude, the test is "a reliable, quantitative assay" for fetal exposure to cocaine. They note that since the drug is trapped in the protein matrix of the hair, it cannot be removed by washing.

Dr Parton said the developer of the assay says drug exposure can be detected with analysis of as few as five or six hairs.

Lower birthweights, gestational ages

Cocaine babies differ significantly

By Paul Szabo

CARMEL, California — Jitteryness is the main symptom seen in infants of women who abuse cocaine, say Californian researchers investigating the rapid rise in numbers of such newborns.

Researchers from the departments of pediatrics and obstetrics at the Harbor-UCLA Medical Center and the School of Medicine at the University of California, Los Angeles also found the infants have several significant differences from babies of women who abuse other drugs.

Stanley Inkelis, MD, presented the study here at the annual meeting of the western section for Pediatric Research.

Records between January, 1982 and December, 1986 were reviewed of all pregnant women and newborns suspected of being exposed to illicit drugs. Subjects were evaluated for study if the newborns showed evidence of drug withdrawal, if the mothers appeared drug-intoxicated during labor, or if the women admitted they used illicit drugs during pregnancy. Urine samples were taken from all subjects; those with positive tests for illicit drugs were included in the study.

Dr Inkelis said statistics show an explosive growth in the number of infants born at the hospital who had been exposed to cocaine alone. The number rose to 66 in 1986 from five infants in 1983, an increase in incidence to 9.33 per 1,000 in 1986, from 0.65 per 1,000 live births in 1983.

Jitteryness, the main symptom seen in these newborns, was seen in 86% of the group.

Dr Inkelis: "Interestingly, the jitteryness seen with cocaine exposure alone was usually not as striking as that seen in infants exposed to other drugs."

He said in babies exposed to cocaine alone, the jitteryness was "more coarse than the fine, desperate, and anxious jitteryness associated with withdrawal from other illicit drugs.

"If one is not attuned to this more subtle form of jitteryness, it may be missed, and it has been on many occasions."

The babies had other withdrawal symptoms — hypertonia, hyperactivity, increased crying, and irritableness — but the incidence of these symptoms was not as high as with the other groups of infants of drug-abusing mothers.

Dr Inkelis said: "Cocaine exposure should be suspected in any neonate who has the constellation of perinatal signs and/or symptoms of drug withdrawal or whose mother has a history of drug abuse."

He advocated urine screening of all pregnant women and newborns at the hospital.

"My feeling is that these babies are being abused *in utero* (and) if the mothers are doing this, why not find out who they are and try to stop it as soon as possible?"

Infants and mothers exposed to cocaine alone were compared to other mothers and newborns exposed to cocaine in addition to other drugs, those exposed to opiates, and to the large population of newborns and mothers exposed to no illicit drugs.

The population exposed to illicit drugs had several characteristics in common, in contrast to the normal mothers and children, such as a lack of prenatal care, a higher number of abortions, and the need for more intense care of the infants in the hospital.

But, the group exposed to cocaine alone were significantly different from other subjects exposed to illicit drugs. Newborns had significantly lower mean gestational ages and significantly lower mean birthweights. There were also more preterm infants in the group and a higher incidence of newborns small for their gestational age.

Addictions and the AIDS epidemic: facing facts

FORT LAUDERDALE, Florida — Ramifications of the AIDS epidemic will encroach more and more on the chemical dependency field, presenting in coming years problems with no easy answers (see page 1).

Drugs and alcohol are now considered co-factors, either through their effect on the immune system or by lowering inhibitions and allowing high-risk sexual behavior.

The American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) in the United States explored the current situation, and future trends, in a symposium on AIDS and Chemical Dependency held here.

Discussions included issues of confidentiality, testing patients for the HIV-virus antibody, staff training, encouraging those at risk to change their style of living to help fight infection and possibly increase resistance to the virus, and improving the quality of life remaining for those with AIDS. Washington Contributing Editor Harvey McConnell reports.

"AIDS now surpasses the cumulative impact of accidents, homicides, suicides, and cancer as the leading cause of years of potential life lost in single men aged 25 to 44 years in San Francisco and New York," says Donald Abrams, MD, assistant director of AIDS activities at San Francisco General Hospital.

It is forecast that in 1991 there will be 54,000 AIDS deaths in the United States. Dr Abrams predicts approximately 8% of the cases, by then, will be among heterosexuals.

There is a large pool of people with the HIV virus, and some have intermediate manifestations of infection or AIDS related-complex (ARC).

Dr Abrams dashed any hope, at the moment, of long-term survival. "It is our clinical impression that this disease is 100% fatal. We have 10% of patients alive at two years after diagnosis of Pneumocystis carinii and patients with Kaposi's sarcoma appear to have an improved survival rate over those with opportunistic infections. In New York, there is a rare patient alive four or five years after diagnosis. But, I think the possibility of 10-year survival after diagnosis is zero."

As for the relationship between various drugs and development of AIDS, "there is an impressive dearth of information. Although there are a lot of tantalizing hints, there are no real answers," declared Rob Roy MacGregor, MD, professor of medicine and chief of the infectious disease section at the University of Pennsylvania School of Medicine, Philadelphia.

Effect of alcohol

He says alcohol and other drugs can affect the AIDS epidemic in two major ways: it can affect the relative infectivity of the virus, or, it can influence the movement of the infected individual from the asymptomatically infected into the ARC group, into the AIDS category.

Dr MacGregor: "We have no real data which suggest that either alcohol or any other drug potentiates the host's susceptibility to infection of HIV virus.

"One could argue that if alcohol and other drugs are viewed as immunosuppressants, they could decrease the risk of each individual cell being infected. But, this does not mean they should be thought of as antidotes."

On the other hand, it is possible an individual with one or more areas of immune function suppressed by drugs may not be able to fend off the virus at the front line of defence, whereas patients who have all areas of the immune-function working may be able to fend the virus off and prevent primary infection even though exposed to the HIV virus.

"There are no data to show one way or the other," Dr MacGregor added.

There is no question drugs have a disinhibiting effect and can put patients in increased risk of exposure.

Dr MacGregor said one of his major interests is the effects of alcohol on the immune response. There is certainly evidence alcohol sets people up for at least bacterial infections, and he is currently investigating effects on cell-mediated immunity.

Studies on marijuana are conflicting. There has been consistent evidence in rodents that cannabinoids suppress both cell-mediated immunity and antibody production, but there is no solid evidence this occurs in people (**The Journal**, May, 1986).

"I would have to say, though, that the weight of evidence does give one pause, especially when one thinks about the long-term chronic use of marijuana."

As for nitrites, Dr MacGregor said the evidence is that it is not an independent risk factor, but it can be considered a marker for the level of promiscuity among homosexual men. "And, the level of promiscuity correlates with the level of infection with the virus."

Dr MacGregor said all lines of evidence lead to concern. Drugs may, in fact, further complicate the level of immune function in someone with HIV infection of the immune cells and may affect the rate that a person progresses from asymptomatically infected to infected.

Those in the chemical dependency field will have to learn to differentiate cognitive impairment of patients with AIDS and the impairment which can also come with alcohol or other drug abuse.

'There is an impressive dearth of information' on the relationship between drugs and AIDS

Susan Tross, PhD, of the department of neurology at Memorial Sloan-Kettering Cancer Hospital, New York, said AIDS dementia complex is now recognized as the most common neurological complication of the disease. Direct brain infection by the HIV virus leads to global cognitive deterioration.

"In the majority of patients, the progression to global impairment is rapid — occurring within two months of the onset of any cognitive symptoms."

Early-stage signs are mental slowing and deficits in recent memory and attention. About half of patients also have problems of coordination, and one-third have increased anxiety and withdrawal.

Dr Tross said awareness of the potential for reactive psychiatric disorders in these patients can lead to brief trials of psychotherapy and of psychopharmacological agents, which can be beneficial.

Dr Abrams, in answer to questions, said one study showed neuropsychiatric impairment in men with the HIV virus, those with ARC, and those with early AIDS.

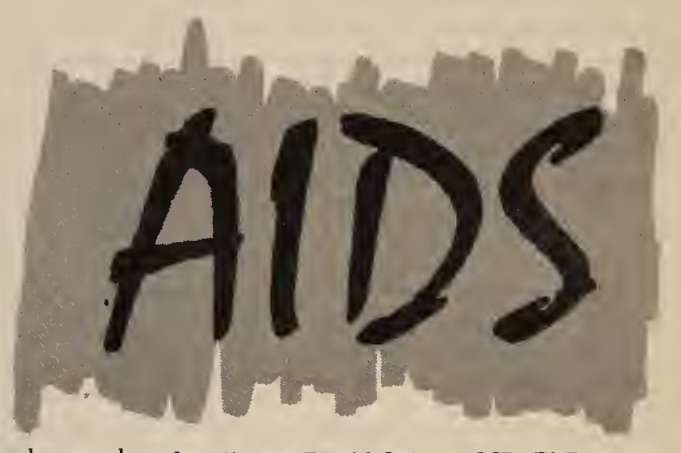
"We have shown you can detect subtle, neuropsychiatric differentiations early in the infection."

A strong relationship between alcohol and other drug use during sex and non-compliance with safe sex techniques to prevent the spread of AIDS has been found in a study among San Francisco's homosexual community by Ronald Stall, PhD, of the department of urban studies at Rutgers University, New Brunswick, New Jersey.

"The relationship of the number of drugs used and the risk of HIV infection are profound," he added.

Dr Stall said studies in the past decade have shown alcoholism rates among homosexual males are as high as any other group in the world, exceeded only by the Irish and Native Americans. However, the samples can be skewed as the studies were generally taken in bars, which is not good epidemiological practice, even though bars are traditional meeting places.

In a household study they carried out in the Castro area of San Francisco, which has been a magnet for homosexual men in the US, Dr Stall and colleagues found homosexuals, as a group, do drink more than their heterosexual counterparts. They found a number are abstainers as well, suggesting there may be a sizeable community of recovering alcoholics in the Castro area.



Dr Stall said among those using drugs in the past six months, the intake was much higher among homosexuals: 78% reported using marijuana, 48% butyl nitrite, and around 50% used cocaine, amphetamines, and barbiturates.

The contradiction was that while the men knew the dangers of high-risk sex, they ignored the guidelines for safe sex. The major reason was their alcohol and other drug use.

Many members of the homosexual community today "do things their mothers told them: don't get colds and don't work too hard. And, there has been a significant cutback in alcohol- and drug-use patterns."

Safe-sex practices

Melvin Pohl, MD, director of the Montevista Center, Las Vegas, Nevada, who is also in private practice, said a positive HIV test has no treatment implications for those with chemical dependency problems. But, it is not certain what the behavioral aspects will be among those found to be positive.

"There is some evidence safe-sex practices go up in response to a positive test, but there are also data that if people get a negative test, safe-sex practices go down."

For people with both AIDS and chemical dependency, "let's not give them more than they can handle; let's remember how impaired they are."

William Hawthorne, MD, medical director of the Mediplex Group, Spofford, New Hampshire, said his group actively discourages patients from having the HIV test until they leave hospital. "Most patients don't want the test — they want a negative result."

A positive HIV test may not provide motivation for those with chemical dependency problems to recover. The employment, health insurance, and financial implications can be profound, leading to more social isolation.

"And, in treatment, if they have a positive HIV test, it is going to be hard to get their attention on recovery.

"I can count on one hand" the number of patients in the group's facilities who are either HIV-positive or who have AIDS, Dr Hawthorne continued. But, there is no question the epidemic presents the biggest challenge yet to the addictions field.

He's talked to other medical directors; while there is a fear that one day they may be overwhelmed, "we seem to have some breathing time to get our act together."

Dr Hawthorne has spent a lot of time with AIDS help-groups in Boston and tried to understand the perspective of drug abusers with AIDS. Their care will be a challenge to accepted standards of care for drug-dependent people.

The epidemic presents the biggest challenge yet to the addictions field

Judgements must be suspended: for example, many of these people do not regard the use of cough syrups and other drugs as using alcohol. "And, you have to accept what the person can do at that (treatment) point, instead of trying to apply a stereotypic view of alcoholism treatment."

Dr Hawthorne said education of the facility staff, at all levels, is vital before HIV-positive or AIDS patients are admitted. Infection should not be a major concern if guidelines set for hepatitis B infection are followed.

Alcohol and other drugs are major co-factors in the development and spread of AIDS, and "I think we have to accept that fact," says David Ostrow, MD, PhD, associate professor of psychiatry and director of psychobiology research at the University of Michigan School of Medicine, Ann Arbor.

It must also be accepted that whatever alcohol problems exist in the homosexual community, the use of marijuana, cocaine, nitrites, amphetamines, sedatives, hallucinogens, and opiates "far outshadows it."

He and colleagues in a multicentre — Chicago, Baltimore, Washington, Los Angeles, and Pittsburgh — study of 5,000 homosexual and bisexual men showed those using the drugs were significantly more likely to engage in sexual practices believed to be the most likely to transmit the HIV virus.

Dr Ostrow is clear: "You can't deal with the AIDS problem without dealing with the substance abuse problem." It is not surprising that with the fear of AIDS, there is a lot of chemical abuse.

Dr Ostrow added that when homosexual men or women enter a chemical dependency program, "they are caught up in fears of 'coming out' to a whole new group of people. They come from altered lifestyles where they often feel rejection. In treatment, they often feel rejection even though the staff does nothing to cause this."

Work together

Can counsellors and patients deal with the problems of alcohol and other drug abuse and HIV infection at the same time?

"I don't have the answer to that," Dr Ostrow says, but he hopes the two groups can work together.

He posed a second question: "How do you find ways to replace the social role and self-acceptance with the gay lifestyle, the so-called fast track, which includes the use of alcohol and recreational drugs? If you take that away, what do you replace it with?"

Dr Ostrow: "If you don't panic when the first AIDS patient comes into your clinic or your program, other staff will see they don't have to panic."

David Smith, MD, founder and medical director of the Haight-Ashbury Free Medical Clinics and research director at the Merritt Peralta Institute Chemical Dependency Hospital, San Francisco, said one of his fears is that "people in the AIDS field, more and more, will be dictating chemical dependency policy," and that many do not have the sensitivity necessary for the chemical dependency field.

Dr Smith said he has known privately-run, chemical dependency programs which actively oppose admission of those susceptible to AIDS because it would give the program a bad name.

Employee assistance programs may not refer, he said, because of fear their people may contract AIDS, and the end result is a loss of revenue.

He thinks the field must issue guidelines on such issues as giving out sterile needles and methadone maintenance.

Any expansion of methadone maintenance should be matched with offers for people to have the chance to take naltrexone and utilize individual counselling.

Next month in The Journal
The needle debate

PRIMARY CARE

A-team helps hospital identify addicted patients

By Terri Etherington

TORONTO — Patients at Roger Williams Hospital in Providence, Rhode Island no longer expect to see Mr T at their door when nurses tell them to expect a visit from the A-team.

Instead, one or more members of an interdisciplinary addictions team is apt to arrive. And, says David Lewis, MD, founder of the program, the team is likely to arrive during visiting hours because that's when the best intervention can take place, when family, employers, and friends are also there to hear the message.

"If you're interested in intervention, if you're interested in getting people to hear what you have to say in a public health way, the general hospital is a super place," says Dr Lewis, also director of the Center for Alcohol and Addiction Studies and professor of medicine at Brown University, Providence.

"You've got a captive population . . . . You've got people in crisis. Their defences are down; they'll hear more in that setting."

The goal is to identify the as many as 20% to 30% of the general-hospital population who have alcohol or other drug problems and to suggest interventions or treatment.

"We are not identifying people on charts with a diagnosis of alcoholism. We are spreading a net to get to the 20%. At the peak of our efficiency, we got to 10% — par for the course is 1%, if that."

The approach is working. In the first five years of the program, the A-team consulted on about 1,200 cases. Of those, 60% accepted referral, either to an ambulatory alcohol clinic in the hospital or to outside service agencies, including Alcoholics Anonymous and Narcotics Anonymous.

"Only a handful," refused outright, 30 or 40 patients of the total sample, Dr Lewis said. And, an independent follow-up of patients who refused intervention showed almost half were sober soon after discharge.

Acceptance of the concept by other hospital staff is key to success of the program, says Dr Lewis. Education and training for all disciplines within the hospital, from trustees, administration, and medical staffs, through housekeeping and kitchen staffs, was an important step in starting the A-team project.

"Whatever they wanted to hear about, that's what we talked about in in-service training," Dr Lewis said. Physicians wanted and got information on enzymes; kitchen staff wanted and got information on marijuana. But, underlying all education and training, the A-team got its message across and built support throughout the hospital.

That support is key, since referrals to the A-team — which includes a doctor, nurse, social worker, and counsellors — come from every area of the hospital.

In the early years, the team got one referral a month, then one a day. By March, the figure sometimes climbed to as many as five per day.

Staff concerns about what happens after patients are identified as either alcohol or other drug abusers also had to be overcome.

Dr Lewis: "There are a lot of fantasies about what happens when you identify alcoholics. The nursing staff thought mostly about the DTs (*delirium tremens*). I said: 'No, they are already here, they are not going to go into the DTs just because we identify them.'

"The only way you can change that (feeling)," Dr Lewis told participants at a one-day conference here sponsored by Ontario's Addiction Research Foundation, "is to go ahead and do it, demonstrate that you can intervene with large numbers and they get better."

Primary health care staffs need addictions sensitivity

(from page 1)

people who may be poor, drunk, crazy, or all of those things — the obvious place for them to go is to a hospital. Hospitals are open 24 hours a day and are 'free.'

"The at-risk population — the alcoholics, the mentally ill, the frail elderly, and any other vulnerable people — have similar needs when they confront a hospital . . . sensitivity by the professionals, sensitivity based on knowledge and experience. They need someone to demonstrate a genuine appreciation of the complexities of the individual situation."

This is often difficult with tight budgets and the time constraints in emergency units, which are designed to get people in, treat them, and get them out.

Phyllis Creighton, chair of the ARF Clinical Institute Board, told delegates: "Every bed in your hospital is potentially a bed for an alcohol or (other) drug patient.

"If I were speaking of any other public health problem of this magnitude (20% to 30%), I would not even be asking the question, 'Why do hospitals need to be involved.' "

All too often, Ms Creighton added, "hospitals, while treating the physiological results of substance abuse, fail to identify and address the basic problem."

David Lewis, MD, director of the Center for Alcohol Studies at Brown University, Providence, Rhode Island, says the solution doesn't have to be difficult or complicated.

Brown University, with a grant from the United States National Institute on Drug Abuse and the US National Institute on Alcohol Abuse and Alcoholism, is developing a model, core, competency curriculum in addictions for medical schools.

The idea, says Dr Lewis, is to expose more primary health care workers — family physicians and general practitioners — to information about alcohol and other drug abuse.

Dr Lewis: "You can't start to educate a bunch of specialists. That is definitely not the way to go. It is the way people are going . . . and they are so zealous about it they are going to continue to do it anyway.

"They are off and running trying to make as many specialists (addictionologists) as possible. So I think it is even more important that I'm off and running trying to do something in the mainstream."

Dr Rankin agreed: "Certainly the so-called field of addictionology is starting to blossom. Yet, if we really think about it, we can have as many addictionologists out there, in Canada and the US (as we want), but it is not going to solve the problem in any really effective way.

"What we are talking about is how to change the world."

Creighton: basic problem

New drug treaty would reduce police handicap

Canada pushing hard to move on syndicates

Anne MacLennan reports from Vienna

VIENNA — The case of two Quebec sisters arrested in Rome, held there, and then acquitted recently of knowingly possessing heroin was a "dead loss" for Canadian enforcement authorities.

An Italian law, written before drug trafficking was a global problem, robbed Canadian police of the opportunity to nab the drug dealers they suspected were waiting in Canada for the heroin, says Rodney T. Stamler, chief, Drug Enforcement Directorate, Royal Canadian Mounted Police.

He told **The Journal** here Canadian police suspected, and were watching, "certain people."

But, the heroin didn't get delivered to Canada, and the police didn't get the dealers, because Italian law did not permit the drug, or a substitute, to be delivered, under police surveillance, to Canada.

This procedure is called "controlled delivery." It means national laws permit countries to allow drug couriers — or "mules" — to continue their journeys and deliveries, knowingly or unknowingly, across national borders and under police surveillance.

Explains Chief Superintendent Stamler: "Say a courier leaves Thailand to take a shipment of heroin to Canada and stops en route in the United Kingdom. If the drugs were discovered there, the UK would, in all probability and without the knowledge of the couriers, try to substitute some or most of the drug. Or, alternately, they'd let the shipment go through and allow delivery to take place.

"We would then not only get the couriers but also identify the criminals waiting for the shipment."

Among other things, the new international convention focusing on drug trafficking (**The Journal**, March, 1986) would require nations to adjust their laws to allow for such deliveries.

Says Chief Supt Stamler: The convention is a "list of things that enforcement, at least, has identified as being deficient at the international level and that creates the biggest problems in terms of identifying major organized crime groups and bases.

"It will mean there will be international standards that should be applied to national laws, which would make it possible to trace, freeze, seize, and require forfeit of proceeds derived from trafficking.

"Only in that way can you eliminate the major motives organized crime has for involvement."

Even two years ago, the prospect of the draft convention's being finalized within a decade seemed remote; the process of drafting, redrafting, getting approval not only of nations but also of the United Nations itself, and finally moving the convention through a complex series of further steps, is extremely slow.

However, the increasing sophistication of multinational traffickers in the face of police working to enforce laws written decades ago; pressure from the UN Secretary-General (**The Journal**, July, 1985) as well as a handful of countries, including Canada; and, increased political interest have moved the convention to centre stage internationally.

With both pressure and leadership from Canada, particularly from Chief Supt Stamler, the convention has been increasingly prominent on the agenda of the United Nations Commission on Narcotic Drugs here.

Stamler: we want the dealers, not just the 'mules'

Then, this year, under a working schedule proposed by Canada, the target for completion of the final draft of the convention was moved to 1988/89.

"To take more time would be unreasonable when you consider the amount of trafficking going on and how much the convention and its implementation in each country would do to prevent some of the problems relative to trafficking," said Chief Supt Stamler.

There is, however, a surprising stumbling block; the people seeking to confront trafficking through the convention are doing so without the sophistication, the expertise, the resources, or the flexibility that their multinational targets have.

A leading expert on financial law and crime, Chief Supt Stamler says lack of knowledge and experience is stumping many enforcement and other authorities.

"They simply don't know what's involved and have no idea of how to go about it. These provisions scare them.

"When you think of bankers and the commercial world and first see words like seizing and freezing and so on, a lot of people are frightened. Most aren't coming at it from a position of experience, knowledge, and background on the subject. Their attitude is naive."

Thus, what is likely to happen, he says, is that "provisions will be adopted, and most countries won't know what the full impact of them will be until we discuss and develop programs and systems to carry them out.

"With respect to the proceeds of trafficking, for example, Canada introduced legislation in 1975 to prevent organized criminals in the United States from laundering money through Canada. So, we did that 10 years ago, and it's nothing new for us.

"I think Canada is probably in the lead in the whole area (**The Journal**, February, 1986), although some countries have very good laws and by good, I mean very strong provisions to seize and require forfeit of all proceeds connected with drug trafficking.

"But, the difference is that they have a lot of onus or burden that shifts to the accused to prove that it wasn't from drug trafficking, whereas we're contemplating a full investigation of money flows. That's a big difference even from what the US has done to this point.

"So, if you do a full investigation on money flow from trafficking cases, you will, at the same time, widen the conspiracy of the drug offence and also identify the proceeds. And that's what's needed. Most people are not doing that; they don't even realize it should be done, or how it can be done. That's the problem."

He said the June meeting in Vienna — the International Conference on Drug Abuse and Illicit Trafficking (ICDAIT) — will be a "great opportunity for ministers to become aware of precisely what the convention involves."

Health promotion in workplace a good first step

Community resources help

By Anne MacLennan

VIENNA — Many employee problems, including those associated with alcohol and/or other drug use, could be prevented if employers established health promotion programs.

"If you wait until you find people dependent on alcohol or other drugs, then you've either neglected prevention, or it hasn't been very effective," says Behrouz Shahandeh. Mr Shahandeh is with the vocational rehabilitation branch, International Labour Office (ILO*), Geneva.

Information and education alone can prevent some problems, he said. The approach has the added advantage that individual workers do not have to be confronted directly if, for example, they are using too much alcohol.

Shahandeh: creating awareness

"You can create an awareness that can lead to recognition by them that if they continue, they will face disciplinary action. At the same time, you can inform them of resources available in the community where they can find help if they need it.

"Sometimes, if you simply communicate your company's policies and procedures, you're telling your workforce where they stand. And, it's good for them to be reminded every now and then of what the situation will be if they are found to have caused an accident by having had too much to drink."

In Mr Shahandeh's view, problems related to alcohol and/or other drug use should be approached comprehensively.

"We feel there are a number of work-related problems associated with alcohol and other drug use but not necessarily use at the dependence level."

He said problems presented by occasional intoxication and regular use of alcohol and/or drugs may be equal to or larger in number than those presented by people who are dependent.

"It's as important to deal with the person who has had too many beers at lunch, or some marijuana, and comes back to operate heavy machinery as it is to deal with people who are dependent."

As for programs to help workers, Mr Shahandeh said development should be slow and systematic.

"If you come across an increasing number of people who are showing symptoms of, say, a drug problem, or if supervisors are reporting too much absenteeism and can't diagnose the problem —these are sometimes clues. Maybe they can be substantiated through medical records.

"But, somebody has to become aware the problem may exist, bring the issue to the attention of others, and pull together the facts and figures — through whatever direct or indirect indicators are available."

He said a small committee is useful to look at various aspects of the work. One necessary task early on is to review the legislation "because you don't want to do something illegal or for which there are no legal provisions.

"For example, in some countries where drug use is totally illegal and if you identify someone as a drug user, you have to dismiss him or her. That's not going to be very useful; our concern is to keep workers on the job."

Another important early task is to consider what resources are available in the workplace and in the community. What can be mobilized?

"A healthy workforce means a healthy community. Somebody who's not alcohol or other drug dependent will not have problems on the road, will not cause fires, and so on. It adds up."

Companies without resources should see how they can link up with other organizations "because you can do a lot without actually paying for everything yourself."

The ILO does not recommend particular program models and stresses that questions about which particular approach to adopt are best answered by people on the spot.

Following a 16-country survey, the branch developed a multi-media kit on employee assistance. It is intended as a step by step guide for employers and trade unions, in general, and, in particular, for resource staff, who are in the best position to identify potential problems and develop programs.

**ILO, Vocational Rehabilitation Branch, International Labour Office, CH 1211, Geneva 22, Switzerland (Tel 99 68 33).*

Firing drug-test failers is no answer

VIENNA — Employee drug screening is only acceptable if it is part of a larger program providing counselling and assistance.

If it isn't, and if screening results in getting employees fired instead of rehabilitated, then employers are simply shifting a new burden onto communities.

"As long as we retain people in employment, we have an opportunity to help them become healthy workers," says Behrouz Shahandeh, vocational rehabilitation branch, International Labour Office (ILO).

"But, when they're screened out of the workplace, where do they go? Where you had an employed, dependent person, now you have an unemployed, dependent person.

"And, unemployed problem drinkers and drug users are very difficult to rehabilitate. As well, it will be difficult for them to find jobs again with that on their records."

He said although the ILO has not developed an official policy on drug screening, there is consensus: "We cannot disagree with the fact there are certain professionals — in the transportation field, in medicine, for example — with a special code of ethics and standards that have to be maintained because the safety, the lives, of other people are in their hands."

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Editor... Letters to the Editor... Letters to the Editor...

Tobacco ad columns slammed

As one of the academics "who abandon ordinary professional conduct in their claims about tobacco advertising," I have read Richard Gilbert's two columns on the subject of the tobacco ad ban with considerable interest (February, January).

My reaction has been one of dismay and distress, the result not of Dr Gilbert's characterization of my conduct, but rather of the extraordinarily misinformed and misleading nature of his comments.

To respond to all the inaccuracies would require at least as much space as the columns. By way of illustration, consider that, in his first effort, Dr Gilbert stated automobile accidents kill more people than smoking. In fact, in the United States, cigarettes kill seven to eight times as many people as do automobiles. I suspect the ratio is similar, if not identical, in Canada.

A second example pertains to his description of the effect of ad bans in Norway and Italy. Dr Gilbert's "facts" are those presented by tobacco industry representatives. He has completely failed to examine the evidence on the other side, such as the fact that the so-called ad ban in Italy is not enforced and has been flagrantly violated since its inception.

As a third example, in his more recent column, Dr Gilbert says the charge that promoting tobacco is unethical could be levelled against the promotion of automobiles, food, plastic products, electricity, and weapons.

With the exception of the last, all of these produce substantial social benefits that considerably outweigh their social costs. (If he does not believe this, I would suggest Dr Gilbert try doing without food altogether.) Cigarettes, by contrast, are the only major consumer product that is hazardous when used as intended and that offers very little by way of social benefit.

Put simply, Dr Gilbert's knowledge of health hazards and his perspective on comparative ethics are nothing short of astonishing.

His reliance on, and apparent belief in, tobacco industry sources suggests a rather extraordinary naiveté or bias. Were Dr Gilbert interested in offering a balanced presentation, he might have read numerous scholarly publications on the subject published within the past year or two.

He cites (Robert D.) Tollison's book, work supported by the tobacco industry. But, I have been told, he expressed an unwillingness to read my 100-page monograph on the subject written for the American Public Health Association (APHA). Dr Gilbert was satisfied he understood my errant thinking by having read my five-page testimony for last summer's Congressional hearing.

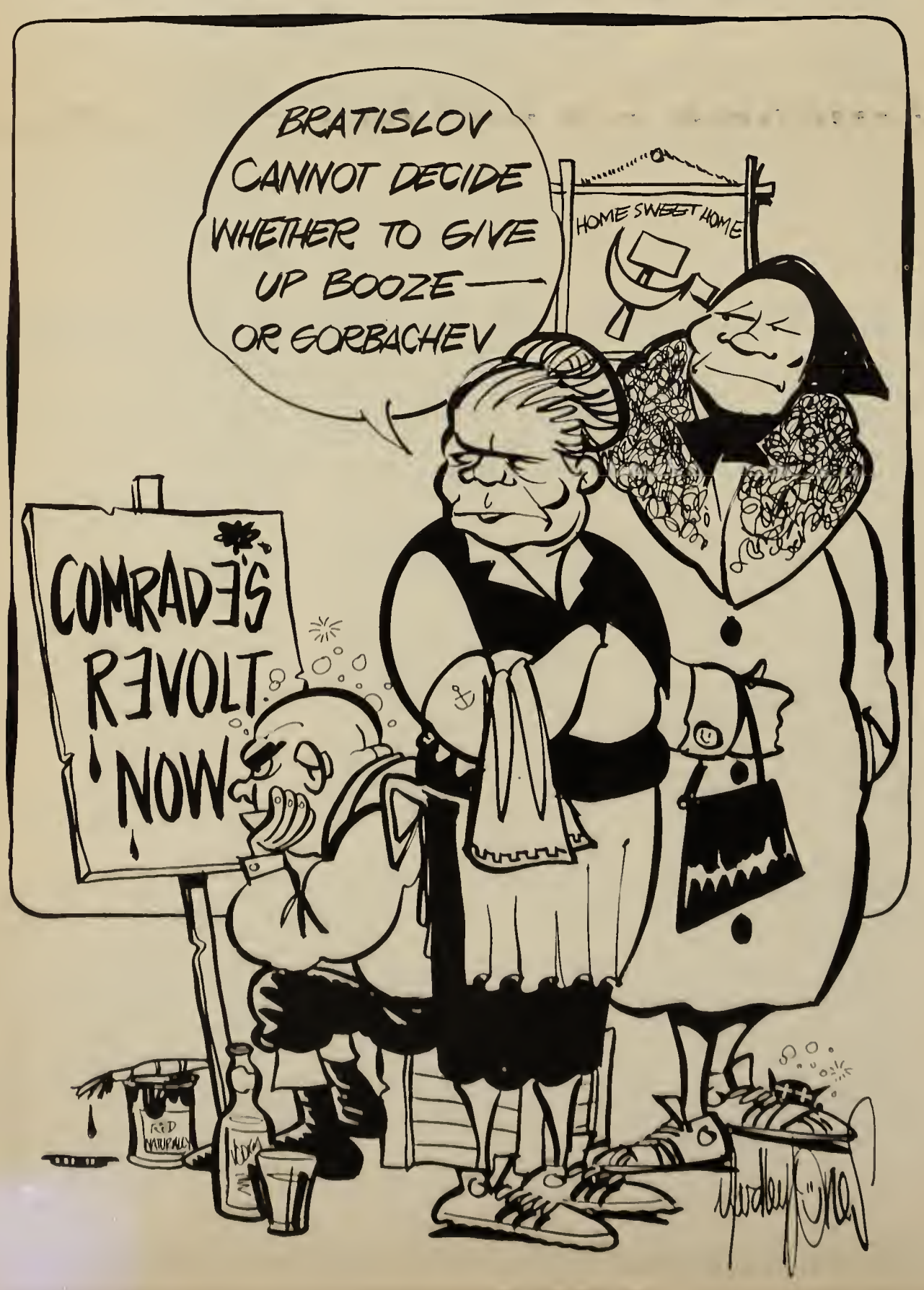
Should Dr Gilbert feel that the APHA is not sufficiently objective, he might wish to consult a peer-reviewed, scholarly article published in the fall, 1986 *Journal of Health Politics, Policy and Law* and coauthored by, among others, a former Surgeon-General of the United States and the former chairman of the US Federal Trade Commission.

The tobacco ad ban debate raises numerous complex and challenging questions.

While I have concluded that the bulk of the evidence and logic strongly favor an ad ban, I readily acknowledge the existence of effective arguments to the contrary.

Unfortunately, Dr Gilbert has offered none of these. I hope your readers will not be taken in by his ill-informed and misleading commentary.

Kenneth E. Warner, PhD
Professor and chair
School of Public Health
University of Michigan
Ann Arbor, Michigan



Howell misses facts

Wayne Howell's well-written column on his trip to Italy is a widespread view (November, 1986).

Alas, there are two facts the learned gentleman seems to have forgotten:

- In Italy, being drunk is a disgrace. In Ontario, we think it's funny or, worse, something to brag about.
- The golden-arches' people (McDonald's restaurants) surely wouldn't have sold billions of those things from five outlets. Is there any field in which more outlets have failed to increase sails?

In any case, demeaning the institution of the family is more cause than result of substance abuse.

Norman Panzica
Toronto, Ontario

Health education counts

I enjoy **The Journal** very much as I am interested in health education. I am a physical education teacher trying to help improve health education in the Northwest Territories.

Alcohol and other drug abuse, especially solvent sniffing and smoking among children, are major NWT health concerns.

I like to keep in touch with the research and other articles you report. I was inspired by your paper to attend one of the many courses the Addiction Research Foundation School for Addiction Studies offers and plan to attend another. Keep up the good work.

Please forward to me a catalogue of educational materials.

Ronald Kennedy
Frobisher Bay
Northwest Territories

TJ needed in staff room

I have found **The Journal** most informative and helpful in my job as a guidance counsellor and special education teacher.

I am retiring from the teaching profession in June. I would therefore ask that my copy be directed to the principal so that one copy finds its way into the staff room.

Thank you for a most enlightening publication. Keep up the good work.

Lawrence Code
W.E. Gowling Public School
Ottawa, Ontario

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: **The Journal**, 33 Russell St, Toronto, Canada M5S 2S1.

COMMENT AND LETTERS

OPINION: The addictions movement

Years of complex, painful work bear fruit

By Larry Hershfield*

There is ample room in the addictions field for discouragement and its bedfellows: cynicism, desperation, and fear. Fresh new "wars" are being launched by politicians; media are craving their own 'crack' high; funding decreases; basic research questions remain unanswered; and, colleagues are burning out.

There are also ample opportunities to indulge yourself, for instance:

- when you're trying to explain what we do to someone in the private sector — parents and headhunters are the most difficult,
- when you're trying to muster up enthusiasm for the newest, long-term planning exercise,
- when you have just been misquoted and the wire services are picking it up,
- when the computer goes down and takes all your files with it,
- when all your clients fail to show, and
- when your supervisor discovers you have no evaluation data for your last three years of work.

At the same time, there are many ways people can manage these pressures, among them the cognitively-based, stress-reduction techniques we recommend to our clients.

The first practice is to reflect on how bad things actually were in the 'good old days' — say the late 1960s and early 1970s. Those years brought an influx of new money, new workers, and new approaches to build on the old; together they form today's addictions movement (industry, some might say).

My personal reflections:

- I sat on interagency committees where there was hostility among many camps. Alcohol/drug, young/old, abstinence only/abstinence as an option, education/policy, and prevention/treatment/research were just some of the dividing lines.
- It seemed every day's mail brought another anti-drug program produced by some United States corporate complex, even more glossy and slick than the last.
- Conflicting claims in the literature, about marijuana for instance, made it difficult to separate facts from conjecture, from expectations, and from hoax. Myths were rampant; acidheads staring into the sun causing blindness was among my favorites.

Hershfield: articles of faith

- Attendance at our movies/discussions depended on the timing and proximity of bingo games. Being anxious to leave one remote community after another strengthened my conviction that exposure to two hours of film would not eradicate deep-seated, rampant alcoholism.
- Media reports and well-meaning educators provided a wealth of information; however, this seemed to be increasing curiosity and experimentation rather than discouraging it. The prospects for community development were bleak. Meetings and forums seemed to attract already-converted family victims of alcoholism or the temperance forces — both legitimate groups in their own, but not likely to build broader bases to advocate policy and service changes.
- Instant experts, fresh from methadone or detox programs, were given platforms to share their half-formed ideas and spin adventure tales of life as a deviant.

These reflections solve nothing; but they make one appreciate all the more the many positive changes our field has seen in the last 15 years.

A list of these changes constitute articles of faith that sustain us in our difficult, complex, and painful work.

The second practice is to use these as affirmations. They don't have to be true; you just have to act *as if* they are. Personally, I'd include:

- the anti-smoking movement that has proven public health approaches work; the drinking/driving movement that is picking up critical mass and is past the point of no return — we will win again. Other issues will likely follow this very pattern;
- community action groups of today (eg, parents and drinking/driving groups) that have the talent, money, clout, and long-term drive to make things happen. They are joining together with the traditional interest groups;
- alcohol's recognition as the major drug problem; the public and professional agendas are thus now much closer;
- inter-provincial and federal-provincial collaboration, an area that used to harden even the most battle-seasoned bureaucrat, that has and will continue to bear fruit: conferences, training packages, rapid dissemination of good works, and so forth;
- professionals and lay groups that have learned a great deal about each other and now collaborate, despite major differences and a volatile beginning;
- our persuasive arguments that no longer rest on moral grounds or vague health threats, but on immediate financial, social, legal, health, and other consequences. We act to support informed choices;
- funding that will improve as pressure on the traditional treatment system makes the case for prevention; private sector money will follow; and,
- employee assistance programs that are well-established vehicles, have saturated various markets, and are a strong base for additional approaches and interventions.

Some time soon, I hope to see some fundamental changes in health care and in our understanding of drug use. But, for now, I'll keep practising.

* **Larry Hershfield is director of the Metropolitan Toronto Regional Office of the Addiction Research Foundation.**

Gilbert is 'flat-out' wrong on tobacco promo

When I was told by Richard Gilbert that he had written a column in favor of continued tobacco promotion (January), I knew it would make for less than enjoyable reading for those of us trying to combat tobacco marketing.

What I didn't expect was that his personal approach to the issue would be labelled by his headline, Unprofessional conduct.

When I read his second column, Tobacco ad debate continued, (February), I noted his inaccuracies and fallacious argument continued, including a misquote of one of my own statements. He was, though, no longer accurately labelling his product, perhaps having taken a lesson from the tobacco marketing people.

He begins his first column by listing three cases where he would allow governments to deny freedom of speech. He cites "pressing national interest" and uses war as an example. That sounds appropriate. Forty-two thousand Canadians were killed in five years in World War II. Tobacco industry products kill that number every 18 months in Canada and have done so for several years.

He cites protection of minors as another justification. The illegal sale of this lethal, addictive product to minors represents a $220 million annual market in Canada. It sounds like a tobacco ad ban meets Dr Gilbert's criteria.

Dr Gilbert also attacks what are, in his view, the "facts" which academics opposed to tobacco advertising get wrong. One of these "facts" is that tobacco is the most advertised product in the United States.

Dr Gilbert is 'flat-out' wrong. If he had taken the time to do his research, a practice he professes to endorse, he would have discovered from authoritative US Federal Trade Commission reports to the US Congress that tobacco advertising does rank number one.

To compound the error, Dr Gilbert decides to extrapolate from Canadian data supplied by none other than the tobacco industry, an industry with a virtually unparalleled history of deception.

He also uses as an example of an error of "fact" the claim that tobacco use is the single largest cause of preventable death in the US. He suggests, rather, that automobiles rank higher. This is a bit of a surprise since tobacco use is responsible, according to US Surgeon-General reports, for more than 300,000 annual deaths in that country, while traffic accidents claim fewer than 50,000.

It is a pity Dr Gilbert did not extrapolate from Canadian data in this instance since the 4,400 Canadians killed on the roads and the over 30,000 killed through tobacco use give a good indication of expected US proportions for these causes of death.

Dr Gilbert dismisses the "anonymous" statements of tobacco and advertising executives who say advertising does, indeed, increase consumption. Since several of these statements, including those by Emerson Foote (former president and chairman of the world's second largest advertising agency) are far from anonymous, it's surprising Dr Gilbert's research could not either turn up the name of the source or obtain, to his satisfaction, confirmation of the report's accuracy.

He fails to understand his professed critical eye should fall not only on independent academics, but also on those whose research is funded by the tobacco industry (eg, J. J. Boddewyn).

The tobacco industry position — that it spends billions annually on advertising which it knows does not increase sales by a single cigarette, that it will spend huge advertising dollars even where there is no competition, and that it will defend to the death the right to continue this waste of money — has been thoroughly discredited in the literature. It was thought nobody outside of the tobacco companies really accepted such nonsense. It is now clear Richard Gilbert does.

Sweanor: shoddy work

Perhaps our most serious concern is that these shoddily researched, unprofessional columns appeared in a reputable addiction newspaper in the first place.

They will be reproduced and presented by the tobacco industry as arguments from a knowledgeable scientist, published in a reputable medical journal, arguing in favor of tobacco advertising. They will appear and reappear for years in industry propaganda kits presented to commissions and legislators. They will undermine the recommendations and work of the Canadian Medical Association, the Canadian Cancer Society, the Royal College of Physicians (and Surgeons), and a host of other bodies which all have called for a ban on tobacco advertising.

This shoddy work argues less for tobacco advertising than it does for a system of outside review of articles of this importance, articles so prominently placed in **The Journal**.

And, assuming that the lack of scholarship is explained by pressures on his time, these articles argue forcefully for a policy of no moonlighting for columnists. Perhaps Dr Gilbert's heavy workload as a municipal politician in Toronto has cut into the time available to do proper research.

David T. Sweanor
Staff counsel
Non-Smokers' Rights Association
Toronto, Ontario

McConnell's marijuana article 'splendid'

Ross: telephone calls, mail

Harvey McConnell's article on the marijuana conference (December, 1986) is a thing of beauty.

We were thrilled to get calls telling us about the article and then to receive it ourselves in the mail. We have made and mailed dozens of copies.

Mr McConnell made a brilliant summary of the most important points made at the conference. I would like to thank him especially for his coverage of my talk on parent involvement in treating adolescent marijuana users.

I am curious about the responses **The Journal** receives and am looking forward to future letters to the editor.

I am writing to you from a one-day conference on compulsive eating disorders and chemical dependency. Most of the participants here are professionals in chemical dependency treatment.

We are the only program to address this dual addiction directly. We are also the only program with a waiting list. Our program is very similar in approach to that of the Health Recovery Center in Minneapolis, Minnesota.

We combine sophisticated biochemical assessment and treatment along with the 12 steps and a counselling component. We find our clients are free of food cravings within two weeks. Follow-up shows more than a 80% success rate with chemically dependent adults one to 3½ years after leaving six weeks of outpatient treatment.

Thank you for reporting on the marijuana conference so splendidly.

Julia Ross
Director
Henry Ohloff Outpatient Programs
San Francisco, California

NEWS AND COMMENT

Self-help program works for 68% of smokers

By Pat McCarthy

CHRISTCHURCH, NZ — Better results than for any other stop-smoking program reviewed in medical literature have been reported for a self-help program here.

Of 142 participants in the eight-week, Stop Ourselves Smoking (SOS) pilot program, 118 finished the course. Of these, 80 (68%) were not smoking at the end of the eighth week, and 61 (52%) were still not smoking 15 months later.

Developed here, the SOS program is led by selected ex-smokers.

A leader's manual and a participant's kit help consolidate coping strategies and learning between cessation sessions. The manual and kit contain information about side-effects, monitoring of smoking behavior, quitting strategies, nutrition, and stress.

Participants in the pilot program were recruited through a media publicity campaign. No attempt was made to select them according to sex, age, or any other criteria. They paid to attend the course.

All were cigarette smokers; the average participant had smoked 22 cigarettes a day for 22 years.

SOS was designed for smokers who know the dangers of smoking and want to stop. Those who labelled themselves "extremely determined" to stop were more successful (70%) than those "determined" (47%), or "somewhat determined" (33%) to quit.

Thirty-eight people completed the course but did not quit smoking. Of these, 30 considerably reduced their smoking. All 24 participants who dropped out took part in subsequent courses.

Reporting in the *New Zealand Medical Journal* (December 10, 1986), health education officers Glen Price and Jiri Davidson-Rada said every course has been filled to capacity.

Israel plans its first anti-drug year

TEL AVIV — Inspector-General of Police David Kraus has announced the first police anti-drug year here without specifying what steps will be taken.

He pointed out the drug "racket" in Israel is in the $500 million to $700 million range, with crime providing most of the money used to buy drugs.

In 1986, police confiscated 200 tons of hashish, 200 kilograms of heroin, and "several tens of kilograms" of cocaine.

The Israeli Military Court recently handed down what is believed to be its most severe sentence to the highest-ranking officer ever charged with drug running.

The officer, a lieutenant-colonel, was reduced to the rank of private, expelled from the army, and sentenced to seven years in prison after he pleaded guilty of trying to smuggle 594 kg of hashish from Lebanon into Israel.

A recent survey of soldiers about to be discharged indicates 8% of the men and 5% of the women have used drugs in one form or another.

GILBERT

From smoker to chain-chewer

Prominent in the work of Britain's Addiction Research Unit (ARU) is the notion of the "alcoholic career" — the unfolding sequence of an individual's lifetime behavior in relation to alcohol (**The Journal**, March). Of particular interest are "change episodes" — events and experiences reported by alcoholics that go with changes in the pattern of alcohol consumption. Of interest, too, is the variability among and within alcoholic careers.

Researchers at the ARU believe understanding of individual alcoholic careers will give them a better handle on the causes and treatment of alcoholism than information about large populations. If we know what precedes a sharp increase in alcohol use, they argue, we can watch for such events, anticipate the worsening of the disease, and take corrective action.

Careers can be built around other drugs, including nicotine. Elaboration of a nicotine-using career may offer insights into the causes and continuation of nicotine use.

Nicotine career

I became interested in the nicotine-using career of Graham Reed when I learned he was among Canada's early users of nicotine chewing gum. He has used it continuously since 1983.

Dr Reed, chairman of a psychology department at Toronto's York University, began smoking when he was 13 years old. He is now 64 and has not smoked since using nicotine chewing gum. Serious smoking began at the age of 19 years when he joined the British Army. Smoking was very much the norm, encouraged by a ready supply of cheap cigarettes — free in combat zones.

Richard Gilbert: Could you have avoided smoking in the armed forces?
Graham Reed: Yes, if I had had enormously strong willpower. Not smoking raised suspicions of effeminacy or, even worse, poetic inclination.

RG: When did you first try to quit?
GR: Almost as soon as the war ended. From 1946 to 1983, I quit at least once a year. As Mark Twain said, few things are so easy.

RG: What happened when you quit?

"I felt I was in thrall to the tobacco companies. My miserable pleasure served little more social purpose than adding to their already exorbitant profits"

GR: There was usually no problem for the first four or five days or even as long as three weeks, contrary to what smokers usually report. Then, there would be a period of stress; or, more often, I would want to concentrate on a piece of writing, and my resolve would dissolve. Sometimes, I would find myself being joyfully surprised that I was not yearning for a cigarette. Then, soon after, I would be equally surprised to find a cigarette in my mouth. My wife may have put it there. She and others found my temper unbearable when I quit smoking. I noticed no change.

RG: Did you enjoy smoking?
GR: I loved smoking. I enjoyed everything about it: the rituals, the smell, the taste, and the effect on my thinking. Sometimes a cigarette seemed to be my only friend.

Politics of smoking

RG: Why did you want to quit?
GR: At first, not especially for health reasons. It was more what you might call the politics of smoking that got to me. I felt I was in thrall to the tobacco companies. My miserable pleasure served little more social purpose than adding to their already exorbitant profits. Another thing was the unfairness of the tax on cigarettes — a special target of British Chancellors of the Exchequer.

Reed right, with Gilbert: 'from 1946 to 1983, I quit once a year'

RG: Were there significant changes in your consumption over the years?
GR: The price of cigarettes generally determined how much I smoked. I suppose there was a change after the war, but the biggest change must have been when I emigrated to Canada in 1969. I went from smoking between 10 and 20 rather small cigarettes a day to between 20 and 30 larger cigarettes.

RG: Was quitting more or less difficult when your consumption went up?
GR: I don't remember much difference.

Tried everything

RG: Had you tried any aids to quitting before you used the chewing gum?
GR: I tried everything. So-called herbal tobacco was touted during and after the war. It was like dried hay or dank hedgerows — smoking at the bottom of a swamp; there was no pleasure at all, except pleasure in virtue. I tried a variety of filtering devices, everything that came on the market. They all involved some kind of cigarette holder, and I wanted the feel of raw paper in my fingers.

I smoked a pipe for a time; it fitted my image. I stopped on medical advice when my frequent grogginess was put down to nicotine overload from inhaling the smoke and swallowing the guck that flowed back down the stem. I thought it was a recurrence of wartime malaria.

At one time, I tried snuff as an alternative. The head of my department in Britain used snuff — a filthy business. He would sniff it in and then blow it out into a huge, khaki-colored handkerchief that he would then inspect in detail. Snuff didn't help. I sucked candies too. My consumption went down a little, but I became inordinately fat.

RG: How did you come to use the gum?
GR: In 1983, I had a bad period of ill-health, mostly hypertension. My doctor said I should cut down to 10 cigarettes a day. He thought I was too old to quit. I followed his advice but found my days dominated by waiting for the next cigarette. Ruses such as cutting cigarettes in half were no help. A 2½-pack-a day colleague had managed to quit using nicotine chewing gum. I asked my doctor for a prescription. The colleague still doesn't smoke. She chain-chews the gum instead

Gum sceptic

RG: What was your doctor's attitude?
GR: Well, never having smoked himself, he always said cold-turkey quitting was the thing to do. He was quite sceptical about the gum, but deigned to give me a prescription. That was September, 1983.

RG: What was your early experience with the gum?
GR: I began using the stronger gum, the idea being that a heavy nicotine load would block the craving. The four milligram-per-piece gum was unpleasant, and I changed to the two-mg prescription after a few days.

RG: How was the stronger gum unpleasant?
GR: It was rather similar to the pipe: nauseating with an overpowering but indefinable taste. I have a hunch many of the failures with nicotine gum happen because doctors first prescribe the stronger gum. Each piece is equivalent to four cigarettes, and the build-up of nicotine can be quite high.

RG: How much of the two-mg gum were you using?
GR: For a week, I was chewing 12 to 15 pieces a day. This diminished fairly rapidly to a plateau of six to seven pieces a day, which was sustained for about six months. Then, for no apparent reason, my intake fell abruptly to about four pieces a day, a level that was maintained for some eight months. During 1985, my consumption fell gradually from about four pieces a day to about 2½ pieces, where it has remained ever since.

RG: Will you give up the gum?
GR: I doubt it. I seem to have reached my asymptote. Each time we meet, my doctor threatens to cancel my prescription; but, if I had to give up the gum, I would definitely go back to smoking.

RG: How do you use the gum?
GR: Well, the first thing is I never start on the gum much before 11 am. When I smoked, I had my first cigarette before breakfast, and it was the one I enjoyed most. I take each piece of gum in five parts, at roughly hourly intervals. I nibble each corner and then take the section left in the centre. In this way, I get about 10 to 12 goes at the gum each day.

No desire

RG: Have you had a cigarette since you started using the gum?
GR: I haven't the slightest temptation to smoke, not the slightest flicker of desire. But, I enjoy people smoking around me — the smell of tobacco smoke. Occasionally, I have quite sensual dreams about smoking. I lovingly light a cigarette and inhale with a passionate pleasure.

By Richard Gilbert

Employment-Related Drug Screening

—A Public Health and Safety Perspective—

TORONTO — The following material was developed by the Addiction Research Foundation (ARF) here as its Best Advice on the controversial issue of urine testing for alcohol and other drug use.

ARF experts in biochemical research, laboratory techniques, employee assistance programs, and occupational research, with assistance from personnel and information specialists, looked at: legal issues involved — employee and employer rights, in union and non-union settings; methods of drug analysis — immunoassay and chromatography; and, public health and safety concerns — the extent of public use of alcohol and other drugs, how use affects safety, and risk-levels involved.

Task force chairman Bruce Cunningham told The Journal this is the first comprehensive study in Canada of all aspects of the issue. The Best Advice is drawn from the full report of his group and is presented for readers as part of The Journal's continuing coverage of the drug-testing issue. (For major articles, see The Journal, February, 1987; November, March, 1986; November, 1985.) — The Editor

Summary statement

Employment-related drug screening is likely to be one of the most contentious issues in labor-management relations in the next decade. The growing practice of employers to institute programs of drug testing — selectively, randomly, or comprehensively — led the Addiction Research Foundation (ARF), Toronto, Ontario, in May, 1986, to establish a task group on employment-related drug screening from a public health and safety perspective. This document presents the recommendations of that group, together with a brief background summary. Its purpose is to contribute to informed public discussion of the issue.

Recommendations

With respect to employment-related drug screening — the term refers to screening for alcohol and other drugs — the ARF recommends that:

- mass or random drug screening for all employees and/or applicants for employment not be implemented;
- drug screening be considered for employees who show deficits in job performance and whose behavior in the workplace is judged to constitute a safety risk to self or others. All such cases be referred to a qualified medical practitioner; the decision to test for drugs be made by this individual;
- pre-employment and continued random drug screening be considered for employees in jobs that pose risk to co-workers and/or the public and that are unsupervised for periods such that evidence of impairment would not normally be subject to observation;
- if drug screening is instituted, the following procedures be followed to guarantee valid, accurate, and confidential results:

— samples should be collected by qualified staff under medical supervision and be forwarded to a qualified laboratory;

— the individual being tested should have the right to provide and to have recorded a statement of current medical or other drug use;

— all positive results should be confirmed by gas chromatography/mass spectrometry. The laboratory should not forward positive test results unless the results have been confirmed by this method;

— the laboratory should communicate test results only to the licensed medical practitioner who forwarded the test samples to the laboratory; and,

— the practitioner should report back to the employer on the results of the testing and his/her interpretation of same in accordance with standard medical ethics and any applicable company policies and collective agreements;

- if drug screening is instituted, employees with confirmed positive test results be referred to an employee assistance program for assessment and, if needed, counselling and rehabilitation;
- if drug screening is instituted, it be preceded by a formal employment policy stating the rationale for the testing and the consequences of confirmed positive test(s) results in relation to continuation of employment.

Background

Alcohol and other drug use is a fact of life in Ontario, especially in the under-30 age category. A 1984 survey indicates 84% of Ontario adults aged 18 and more use alcohol, 11% use marijuana, and 3% use cocaine. (1) In the same survey, 90% of 18 to 29 year olds reported using alcohol, 28% marijuana, and 7% cocaine.

There is no doubt that alcohol and other drug abuse is a significant public health and safety problem. Alcohol and a number of illicit and controlled drugs have been shown to alter motor coordination and/or perceptual ability; their use can thus result in industrial and road accidents. (2,3)

The actual extent of alcohol and other drug abuse in the workplace is unclear, especially in Canada, where no statistics are available.

However, studies emerging in the United States suggest that drug monitoring is having beneficial effects, especially when combined with employee assistance programs. Although some programs started without the backing of scientific evidence, their results support the premise that monitoring of drug use, whether at work or off-site, reduces accidents in the workplace.

Urine testing for various drugs can be done accurately if the proper equipment, staff, and procedures are used. Although the legal right of employers to require urine tests of current employees is not clear for all situations, urine testing may be permissible for new job applicants.

However, urine testing is intrusive. It requires that a urine sample be obtained in full view of a staff person not necessarily known to the donor. Once in the possession of the employer's agent, it can be tested for a variety of compounds, not always with the full consent of the donor, to whom the results are not always communicated. Moreover, urine tests can only measure past use and not impairment on the job.

Therefore, we suggest that urine tests should only be used where the safety of the public, the employee, or other workers is involved, or as a supplement to indications of impairment that are observed by other means.

There is direct as well as circumstantial evidence to indicate that impairment from the use of alcohol and other drugs in Ontario workplaces could affect individual and public safety. *Heavy* use of alcohol and other drugs does correlate with an increased risk of accidents. But, it is not clear what, if any, increased risk can be attributed to *moderate* alcohol or drug use away from the workplace.

For these reasons, we suggest that urine testing should be limited to employees in occupations that pose a risk to co-workers and/or the public.

Where special precautions are warranted, blood tests would be more appropriate than urine screens, as blood levels correlate more accurately with actual levels of impairment.

But before blood tests are utilized, there should be other indications of impairment, or the work situation should be one that justifies such measures to prevent accidents or to allay legitimate public concerns.

In situations where impairment is suspected, the decision to test should be made by a qualified medical practitioner. Managers, supervisors, or security staff can refer to a medical practitioner but should not have the authority to require tests. In this way, confidentiality can be preserved while providing protection for the public and/or other employees. When test results are returned to the workplace, they should go back to the medical practitioner, who is bound by discipline and law to preserve confidentiality.

Employers should also note that other interventions, such as health education, employee assistance programs, regular performance appraisals, and security checks, should also be considered in any attempt to reduce risks due to drug abuse in the workplace.

Some of the interventions currently used in Ontario are:

— employee assistance programs, which provide counselling and rehabilitation for employees with problems;

— union counsellor programs, which train union members to help fellow workers in the use of community resources to deal with problems;

— health education programs, which suggest positive options to lifestyle and health habits that could lead to addiction problems;

— security inspection programs, which train security staff to recognize drugs and signs of impairment.

Our experience suggests that all such interventions are most effective when they are instituted as cooperative efforts among labor, management, and health services.

References

(1) *Statistics on Alcohol and Drug Use in Canada and Other Countries*, Addiction Research Foundation, Toronto, 1985.

(2) Vingilis, E., in *Research Advances in Alcohol and Drug Problems* (Ed, R. Smart et al), Vol 7, pp 299-342. Plenum Press, New York, 1983.

(3) Shain, M., *Accident Analysis and Prevention*, 239-246 (1982).

A Background Reading document to this Addiction Research Foundation Best Advice on Employment-Related Drug Screening — A Public Health and Safety Perspective *is available from the ARF, Information and Promotion, 33 Russell Street, Toronto, M5S 2S1.*

NEWS

Alcohol ads: informing or manipulating public?

Health, safety officials debate industry reps

Bates: grim

Joslin: unfounded

Tripp: shrewd

Kendall: trivial

By Mark Kearney

TORONTO — In the approximately three hours it took to complete a recent public meeting on alcohol advertising, someone in Canada was killed in a drinking-driving accident.

Some people believe lifestyle advertising by beer and wine companies contributes to the accident statistic and want more restrictions on how alcoholic beverages are portrayed on television and in other media.

"Unless we can convince our breweries to show restraint in their advertising, we'll never get our young people to show restraint in their drinking habits," John Bates, president of PRIDE (People to Reduce Impaired Driving Everywhere), told the public meeting.

Mr Bates provided some grim statistics: one Canadian is killed every three hours in a drinking-driving accident; alcohol abuse costs Canadian society at least $1.5 billion annually.

The forum, Alcohol advertising: information or manipulation, was sponsored by the Addiction Research Foundation here.

Much of the problem lies with young people, Mr Bates said. They, in turn, are influenced by ads they see on television and hear on radio.

"Lifestyle advertising by the breweries is undermining everything we're trying to do," Mr Bates said.

Barry Joslin, vice-president of public affairs for Molson Breweries of Canada, said such charges are unfounded. The breweries play an important role in telling people about drinking in moderation and the responsible use of alcohol. He said anti-drinking-driving messages on TV and billboards are an example of what the industry does.

Only 2.8% of Molson's advertising budget goes toward such media as rock videos, he added, and many of the viewers are older than the legal drinking age of 19 years. Most brewery advertising, he said, is aimed at getting current drinkers to switch brands, a trend more evident in Canada in the past few years with the advent of new products and bottles.

Mr Joslin: "If there's been one remarkable change in the industry (in the past five years), it's the amount of brand switching that has gone on."

Other industries also use lifestyle advertising, he added, but beer and wine makers are unfairly singled out.

"Virtually all (commercials) are built around some combination of image and product attributes to sell a product, and no one seems to interpret that use of image in the same way they do for beer advertising."

An exception is advertising by the Upper Canada Brewing Company, said its president Frank Heaps. The company doubled its small share of the beer market (less than one-quarter of 1%) by informative ads that don't portray exciting lifestyles.

Mr Joslin said young people are intelligent enough to know lifestyle advertising doesn't encourage excessive drinking; the beer companies are simply trying to get a larger market share than their competitors, not encourage underage adolescents to become drinkers.

But, Garwood Tripp, a senior communications program officer with Health and Welfare Canada, said the ministry doesn't "buy the market share argument.

"Aiming commercials at underage people is a deliberate and shrewd strategy. It helps ensure the future prosperity of the brewing industry by priming young people to become beer drinkers," said Mr Tripp.

"We believe alcohol advertising is a barrier to health promotion. In our analysis, the persuasive, repetitive, and appealing nature of the advertising message used by the brewing industry is a significant factor influencing the drinking practices of young people."

Kay Kendall, director of communications and public relations for the Association of Canadian Distillers, disagrees, saying that advertisers are incorrectly blamed for alcohol abuse problems. Anyone blaming commercials either doesn't understand advertising, underestimates the public's "good common sense," or is trivializing the causes of alcoholism and abuse.

She cited a study by the United States Federal Trade Commission which concludes there is no basis to the argument that advertising affects alcohol abuse or encourages consumers to drink more.

There are better ways of attacking alcohol abuse, said Ms Kendall: "I would suggest to you that only a good, mixed balance of research, treatment, and preventive education will successfully combat alcohol abuse."

Broadcasting regulations that govern alcohol advertising were also a forum issue. David Bond, president of the Canadian Association of Broadcasters, says the association doesn't want further restrictions (**The Journal**, November, 1986) because alcohol is legal and should be treated no differently from other lawful products.

Mr Bates said he recognizes the need for alcohol manufacturers to advertise just as anyone else does, but commercials shouldn't be aimed at adolescents or connect the product with driving.

"We believe it is nothing short of obscene for a beer company to sponsor an automobile race."

Andrea Holmes, a student representative here of Toc Alpha (the youth arm of Alcohol and Drug Concerns, Inc), said it's also wrong for alcohol advertising to use celebrities with whom young people identify, especially on rock video shows where 50% of the audience is less than 18 years old or sports shows.

"Most adults only respect athletes, whereas the kids idolize them," said Ms Holmes.

Mr Joslin said there are other reasons — peer pressure, family attitudes, and a general pessimism about the state of the world — that cause young people to abuse alcohol and drugs.

Irish bishop left red-faced by drinking/driving charge

CORK — A London court has suspended an Irish bishop's driving licence after his conviction for impaired driving.

Bishop Eamon Casey, the bishop of Galway, was in England on holiday when the offence occurred.

The bishop, who has been actively campaigning for special counsellors to tackle the problem of teenage drinking, was stopped for speeding.

Subsequent breath tests registered nearly twice the acceptable limit.

The conviction has clearly embarrassed the popular clergyman, who apologized to his diocese through a letter read at Sunday masses.

His solicitor told reporters Bishop Casey drank too much during a meal with friends: "Throughout the evening, friends and waiters kept topping up his glass. He was unaware of how much alcohol he had consumed."

The Irish temperance group, the Pioneer Total Abstinence Association, said they were saddened by the case, particularly since the offence occurred on Temperance Sunday.

HOWELL

Seen in a rear-view mirror

"Don't look back," said pitching-mound philosopher Satchel Paige: "Something might be gaining on you."

What's gaining on me, a sometime dabbler in the surreal, is reality. Last August, I happened across a news item about a Texas entrepreneur who was marketing a home urine-testing kit for $24.95. This, I thought, is going to give *Family Ties* a whole new dimension.

And with that in mind, I imagined a scene from a typical United States family (the *Family Ties* family naturally) with good old Dad Keaton pacing in the hallway and shouting at the closed bathroom door, "Alex, you are not going to get the family car to take Ellen to the prom unless you produce a specimen. I mean it Alex. No specimen, no Chevy . . . ." And so on, and so forth, with lots of canned laughter.

I was working up a column on this warped sitcom theme when I got sidetracked by another idea: in the era of do-it-yourself drug testing at less than $25 a pop, what is to stop someone from merchandising drug-free urine or urine substitutes for people who wish to circumvent the testing procedures? This idea eventually grew into my September, 1986 column, a column purporting to be a 1996 *Consumer's Report* on the merits and deficiencies of various commercial urine substitutes.

A kitten chasing its own tail may be involved in a pointless activity, but it has the virtue of being cute. A columnist who writes about another column he wrote — or even worse, writes about the writing of another column he wrote — had better have a point to make. Even an indulgent reader might view such an exercise as too cute for words — in any event, I hope you will bear with me.

When I wrote the September, 1986 column, I did not look back and had no idea they were gaining on me; I thought I was well out front.

Already, one company has dehydrated, drug-free urine specimens on the market

Consequently, my first concern was that a reader might think the do-it-yourself, all-inclusive, home urine-testing kit was a figment of my imagination. So, I described it in concrete terms, giving place of origin, trade name, and exact price.

I took pains to make sure this product was accepted as a reality. If readers were assured such a product existed, I reasoned, their minds would be less inclined to boggle at the imaginary products I facetiously predicted would exist in the near future: organic, semi-synthetic, and synthetic urine substitutes tradenamed Pseudo-P, P-Plus, Pure-P, and Whizaway.

Notwithstanding the reality of my premise (the existence of a home-testing kit for all and sundry to use or misuse at their pleasure), I thought readers might still find my development of the premise (P-Plus in "pop and pour" ampules) a little far-fetched.

That being the case, I made a point of mentioning that the various urine substitutes were made by companies already producing demonstrably anti-social products, namely companies making automobile radar detectors or "fuzzbusters." And, I was careful to project the initial appearance of these products into the future; they appeared, I said, in "late 1987."

The irony is, they were gaining on me even as I was so carefully — and, in retrospect, so cautiously — developing what I thought was a tongue-in-cheek scenario. Because here we are, in the spring of 1987, and already Byrd Laboratories of Austin, Texas has dehydrated, drug-free urine specimens on the market.

There I was, in the summer of 1986, thinking I was so clever — and so outrageous — to have conceived of "pop and pour" ampules and "zip-lock" openings for phony urine specimens. And, at approximately the same time, some serious guy in Texas was applying for a patent on dehydrated urine specimens (just add water and shake), a practical solution — pardon the pun — I had not even considered.

While I was describing — in the summer of 1986 — the merits of my imaginary Pure-P's innovative "variable-amount" packaging designed to foil urine testers suspicious of standard-volume samples, and while I was describing the virtues of my imaginary Pseudo-P (namely, the zip-lock opening for quick and easy urine substitution under trying conditions), someone at Byrd Laboratories was putting the finishing touches to *Success in Urine Testing*, a pamphlet that advises: "Switch your urine for a 'quality' sample. Drug-free urine may be stored in urostomy or saline bags or in condoms and then hidden in your underwear. Keep in mind that testing personnel often check samples to see whether they are warm."

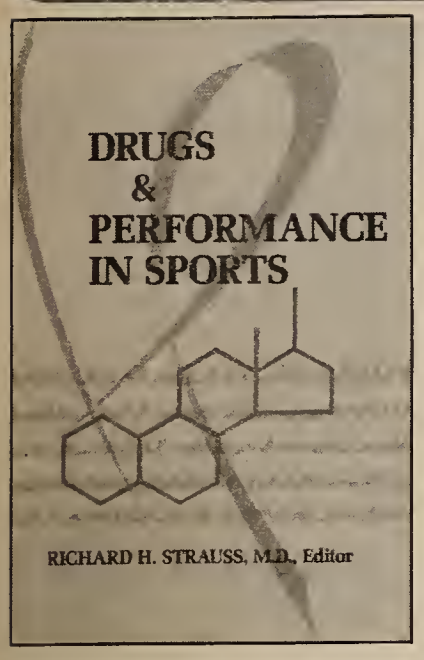
What can I say: they're not only gaining on me, they're pulling ahead.

By Wayne Howell

REVIEWS

New Books

by MARGY CHAN



This book, written by experts in sports medicine, is very readable. The first part deals with drugs and their perceived or real enhancement of athletic performance; anabolic steroids, stimulants, depressants, and blood doping are discussed. The book also covers the ethics of drugs in sports as well as nutrition and physical performance, drug testing, and psychological aids to performance.

The second part discusses effects of therapeutic drugs on sports performance, especially on the athletes' musculoskeletal and cardiovascular systems.

At a time when drug use by athletes is frequently in the news, the book provides useful information for physicians, athletic trainers, nurses, and athletes themselves.

W. B. Saunders, Philadelphia. 1987. 221 p. ISBN 0-7216-1865-0.

Childhood and Chemical Abuse: Prevention and Intervention

. . . edited by Stephanie Griswold-Ezekoye, Karol L. Kumpfer, and William J. Bukoski

In North America, more and more teenagers use alcohol and a variety of psychoactive drugs; the incidence of first use occurs at younger ages. Prevention of chemical dependency is now widely accepted as the most cost-effective method of dealing with alcohol-and other drug-related problems.

This special journal issue is a useful account of current knowledge about prevention relating to children and adolescents. It reviews causes and correlates of chemical dependency, including family, environmental, and genetic influences. The current approaches to prevention in the family, the school, the local community, and society in general are discussed. Current intervention strategies and various treatment approaches applicable and available to youth are identified.

The volume is of value to mental health specialists, child development specialists, early childhood educators, and those in special education.

Also published as an issue of the Journal of Children in Contemporary Society, *Vol 18, no 1/2. Haworth Press, New York, NY. 1987. 299 p. $24.95. ISBN 0-86656-580-9.*

Prevention: Alcohol and the Environment —Issues, Constituencies, and Strategies

. . . edited by Norman Giesbrecht and Ann E. Cox

This collection of papers was delivered at a 1985 Toronto symposium discussing the application of research in developing strategies and policies to reduce or prevent alcohol problems.

The papers and workshop summaries provide perspectives and findings of researchers and programmers from a wide range of institutions. Current issues in community-based program planning and in building local support for community alcohol problem prevention are covered. Environmental and public policy issues which must be addressed as part of local prevention efforts are examined.

The material is current; the scope is North American. The book will interest both community program developers and program researchers.

Addiction Research Foundation, Toronto. 1987. 240 p. $18.50. ISBN 0-88868-141-0.

Drug Dependence and Alcohol-related Problems

Community health workers can play a crucial role in early identification of alcohol and other drug misuse in the community. They can help in recovery and rehabilitation, as well as by promoting understanding of problems within the community.

The first section is geared to health workers with elementary education and some months of training in primary health care. It outlines, in simple language, the problems caused by alcohol abuse and other drug dependence and the different approaches in assessing the community, the individual, and the family.

Suggestions for action during treatment and rehabilitation plus ways to mobilize the community to combat drug abuse are provided.

The second section covers guidelines to curriculum development for trainers of community health workers.

World Health Organization, Geneva. 1986. 34 p. ISBN 924-154-2128.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Crack

Number: 779.
Subject heading: Cocaine.
Time: 15 min.
Synopsis: This program is from the United States National Broadcasting Corporation. Roger Mudd interviews people who have studied "crack." The new drug of choice among many US people is cheap, widely available, and easy to make. It is more addictive than heroin and affects the user faster than regular cocaine. The effect lasts only three to five minutes, motivating repeated use. Law enforcement does not appear to be effective.

General evaluation: Good (4.1). The film provides basic information about crack and could reinforce attitudes against its use. General broadcast is recommended.
Recommended use: With a resource person, the film could be used with general audiences.

Wasted

Number: 778.
Subject heading: Drugs and youth.
Time: 27 min.
Synopsis: The film opens with the funeral of a young drug user. Young people talk about their drug use and how their parents and other adults are poor role models. Individually, they talk about what they do now instead of getting high. The narrator provides statistics and states that most young people who are in jail are there because of drugs. He concludes that every young person will have to make a choice about drugs.
General evaluation: Fair to good (3.5). This film is a montage, and the selective use of statistics and its general tone is depressing.
Recommended use: With a resource person, the film could be used with health professionals.

Career Opportunities

NEWS

Prevention program reaches parents in the workplace

By Harvey McConnell

WASHINGTON — Commitment of parents to educate their children about drugs is the best way to reduce adolescent drug use by the year 2000.

And, the best place to reach parents is in the workplace.

This is the reasoning behind an awareness program drawn up by the American Council for Drug Education (ACDE) in the United States.

"In brochures, we don't moralize about drugs or talk about drug use as an ego issue, we just give straight information," says Lee Dogoloff, council executive director.

The drug awareness program has two aims.

"The first is to help emloyees understand what is at stake with drugs in the workplace and to educate them not only from the standpoint of a drug free-workplace, but also the employer's serious concern about the issue. Just as kids are a captive audience in schools, parents are a captive audience at the workplace.

"Secondly, if there is any hope for the goal of returning to pre-1960s adolescent drug use by the year 2000, the only way is to begin to enlist the commitment of parents right now."

Mr Dogoloff says the majority of workers do not use illicit drugs and probably want to do drug education with their children. "But, they don't know how to do it. And, we have to remember parents impart primary values and are the most important educators of their children. You have got to teach them how to do it (drug education)."

Health warnings for snuff packs

WASHINGTON — Three warnings, rotated every four months, have begun appearing on all packets of chewing tobacco and snuff sold in the United States.

The Federal Trade Commission told manufacturers they must warn on labels: "This product may cause mouth cancer," "This product may cause gum disease and tooth loss," or "This product is not a safe alternative to cigarettes."

The warnings come as the use of smokeless tobacco products by young people continues to climb (The Journal, March, 1986). An estimated 12 million people now use some form of smokeless tobacco. A rise in consumption has been coupled with a rise in cancer and other disease in users.

Colleges called soft on drug use

WASHINGTON — United States Secretary of Education William Bennett has criticized US colleges and universities for not being tough enough on drug use among students.

He told a conference here the problem could damage higher education in the US severely unless more attention is paid to the problem.

"It is an offence to the reality, the spirit, (and) the interest of higher education for drug use to be around, to be in plain public view," Mr Bennett said.

He called for officials at colleges and universities to take the lead in trying to end drug abuse by "eliminating any trace of public or institutional tolerance of the practice."

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Behavioral Interventions Course — April 6-8, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Drugs and Geriatric Care — April 23-24, Toronto, Ontario. Information: Drugs and Geriatric Care, Conference and Seminar Services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

Orientation to Employee Assistance Programs: A Workshop for Professionals and Students — April 25, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Addictions Foundation Atlantic Conference 87 — April 26-30, Saint John, New Brunswick. Information: Roger A. Alain, information officer, Alcoholism and Drug Dependency Commission of New Brunswick, PO Box 6000, Fredericton, NB E3B 5H1.

1st Pacific Institute on Addictions — May 5-8, Langley, British Columbia. Information: Karl Burden, Alcohol and Drug Concerns Inc, 11 Progress Ave, Ste 200, Scarborough, Ontario M1P 4S7.

Emergency Room Aspects of Crack and Cocaine — May 6, Toronto, Ontario. Information: Lorne Greenspan, Emergency dept, Toronto General Hospital, 101 College St, Toronto, ON M5G 1L7.

Medical Aspects of Crack and Cocaine Abuse — May 6, Hamilton, Ontario. Information: F.G.H. Baillie, director, Emergency services, Chedoke-McMaster Hospital, Chedoke Hospital Division, Box 2000, Stn A, Hamilton, ON L8N 3Z5

Prevention Congress III, Working Together to Build Healthy and Supportive Communities — May 6-8, Kitchener/Waterloo, Ontario. Information: Prevention Congress III, Lutherwood, RR 3, Waterloo, ON N2J 3Z4.

29th Annual Assembly of the College of Family Physicians of Canada — May 10-13, Halifax, Nova Scotia. Information: College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario M2K 2R9.

PRIDE Canada 3rd National Conference on Youth and Drugs — May 14-16, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

87th Annual Conference of the Canadian Lung Association — May 29-31, Montreal, Quebec. Information: Les McDonald, director, Health Education and Program Services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

Work and Well-being 87 — June 12-14, Edmonton, Alberta. Information: Canadian Mental Health Association, #200, 12120 - 106 Ave, Edmonton, AB T5N 0Z2.

Summer School for Addiction Studies — July 6-24, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1

28th Annual Institute on Addiction Studies — July 12-17, Hamilton, Ontario. Information: Betty Collins, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

United States

2nd Annual Southeast Conference on Addictions — April 9-12, Ft Lauderdale, Florida. Information: Barbara Goldberg, director, education and information, Center for Recovery, JFK Hospital, 4800 S Congress Ave, Atlantis, FL 33462.

Adult Children Of Alcoholics — April 15-19, St Simons Island, Georgia. Information: ACOA workshop, PO Box 646, Sea Island, GA 31561.

Southwest Conference on Wellness — April 23-25, Tempe, Arizona. Information: Diane C. Fausel, conference coordinator, Community Resource Associates, 8338 E Buena Terra Way, Scottsdale, AZ 85253.

Conference of the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) — April 23-26, Cleveland, Ohio. Information: AMSAODD, 12 W 21st St, New York, NY 10010.

National Alcoholism Forum and Medical Scientific Conference on Alcoholism: Alcohol and Sports — April 23-26, Cleveland, Ohio. Information: Forum coordinator, NCA, 12 W 21st St, New York, NY 10010.

20th Anniversary Haight-Ashbury Free Medical Clinics Drug Abuse Conference: Chemical Dependency Treatment and the Clinically Challenging Client — May 2-3, San Francisco, California. Information: Mim Landry, Haight-Ashbury Education Group, 409 Clayton St, San Francisco, CA 94117.

Northeastern Conference on Alcohol and Drug Dependence — May 3-6, Newport, Rhode Island. Information: Jane A. Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Road, Newport, RI 02840.

National Conference on Alcohol, Drugs and Women — May 3-6, Denver, Colorado. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St, Ste 181, Washington, DC 20001.

Abroad

International Symposium: Medical Education and Alcoholism — April 20-23, Santiago, Chile. Information: Alfredo Pemjean, Universidad de Chile, Facultad de Medicina, División Ciencias Médicas sur Proyecto: Educación Médica y Alcoholismo Correo 10-D, San Miguel, Santiago, Chile.

3rd Annual International Industrial Alcoholism Symposium — May 25-27, Frankfurt, West Germany. Information: Sara Bilik, symposium chairperson, Conecta Partners, Berger Strasse 211, 6000 Frankfurt 60 FRG, West Germany.

16th International Institute on the Prevention and Treatment of Drug Dependence and the 33rd International Institute on the Prevention and Treatment of Alcoholism — May 31-June 5, Lausanne, Switzerland. Information: International Council on Alcohol and Addictions, Case postale 189, 1001 Lausanne, Switzerland.

International Symposium on Alcohol and the Brain and the 7th Annual Conference of the Australian Medical Society on Alcohol and Drug Related Problems — Aug 20-22, Brisbane, Australia. Information: B. C. Shanley, alcohol research unit, Dept of Biochemistry, University of Queensland, St Lucia, QLD, 4067, Australia.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

International Symposium on Alcoholism and Drug Abuse Among Seafarers — Oct 7-9, Vigo, Spain. Information: J. Tejeiro, Centro Preventivo è Assistencial do Drogodependencias do Concello de Vigo, Rua Uruguay 15, Vigo, Spain.

Heather Graham

The marketplace — illicit drugs in Canada

OTTAWA — Each year, the Royal Canadian Mounted Police (RCMP) publishes a comprehensive review, from the enforcement perspective, of illicit drugs in Canada.

They look at — in order of RCMP priority — heroin, cocaine, chemical drugs, and cannabis: where the drugs originate, with whom, how they are transported, by what routes, how much the RCMP seizes once the drugs reach Canada, and what the trends indicate is likely to happen in the next two years.

The Journal *presents a summary of this information by Managing Editor* Elda Hauschildt, *from the 1985/86* National Drug Intelligence Estimate *just released by the solicitor-general's office and prepared by the Strategic Intelligence and Publications Branch of the RCMP Drug Enforcement Directorate here.*

HEROIN

Trends to 1988

• Mexican black tar heroin should begin to make inroads into the Canadian illicit drug market; seizures in the United States are increasing. The drug's availability, high purity, and lower price will make it popular; heroin injuries and deaths will likely rise proportionately.

• Vancouver, Toronto, and Montreal should remain the principal areas of heroin abuse and distribution, although smaller centres will begin to see the drug. Air transport will remain as the primary means of importation, but, as Mexican black tar availability increases, importing by land from the US will increase.

• Southeast Asia will continue as the major source of Canadian heroin. The establishment of clandestine laboratories in Southwest Asia and upheavals in opium-producing countries, however, could result in increased supplies from Southwest Asia.

• Sri Lankan and Nigerian drug traffickers are expected to become more involved in moving Southwest Asian heroin to Europe, Canada, and the US.

• The Bekka region of Lebanon — largely under Syrian control — will keep producing high-quality opium and heroin; new underground laboratories will be set up in Syria; and, the refined heroin will then be moved to Europe and North America.

1985/86 data

Sources: Southeast Asia supplied an estimated 72% of Canada's illicit heroin in 1985. Whatever the professed political motives of insurgent groups in the area, almost all are involved in growing, refining, trafficking, and/or direct sales of heroin.

Most Golden Triangle (Thailand, Burma, and Laos) heroin destined for foreign markets is converted into morphine, heroin, or other opiate narcotics in clandestine laboratories outside of Thailand. The Thai/Burma border continued to be the major outlet for illicit narcotics, with 80% to 85% of all opiates passing through the area into Thai and international markets.

Hong Kong is a high profile transit country used by international traffickers operating out of the Golden Triangle. And, Southwest Asia remains a significant source of Canadian illicit heroin. Narcotic traffickers in Pakistan, Afghanistan, and Iran are the principal sources.

India, the world's largest producer of licit raw opium, has become a major transit point for narcotic shipments to North America. Authorities estimate the opium traffic from Pakistan to India is as high as 700 kilograms to 800 kg per month.

In Lebanon, traffickers are known to be active in opium poppy cultivation. The country is also a key processing and transshipment centre. Turkey, Greece, Egypt, Italy, France, and the Federal Republic of Germany have also been identified as major trans-shipment points.

Mexican heroin has been only a negligible portion of the Canadian illicit market, but reports indicate small quantities of black tar heroin are penetrating the Canadian border and are available on the West Coast and in Central Canada.

Seizures: The RCMP charged 424 people with narcotic-related offences in 1985, a rise of 6% from 1984. The increase was primarily in the area of major trafficking; the pattern reflects the RCMP's targetting of higher levels of violators. The shift was also reflected in the 58% increase in the quantity of heroin seized by the RCMP and Canada Customs — 63 kg in 1985.

The increase in size and number of 1985 seizures, together with price and purity index data, clearly indicate heroin availability increased in Canada. When heroin is in short supply, diverted pharmaceuticals are abused by the heroin-user population. There remains a secondary user population in Canada who rely solely on legal pharmaceuticals diverted to the illicit market.

COCAINE

Trends to 1988

• The widespread availability of cocaine in Canada should persist into the 1990s unless enforcement efforts in South America severely disrupt international trafficking. If the enforcement programs there work, cocaine seizures and related charges here may stabilize.

• South American enforcement efforts are pushing traffickers away from traditionally established areas to other countries and increasing the possibility of clandestine laboratories being set up here.

• Abuse of more potent cocaine derivatives and cocaine use in combination with other substances is expected to become more prevalent. If this trend occurs, related health problems will follow.

• Outlaw motorcycle gangs (**The Journal**, February) are expected to be increasingly involved in cocaine trafficking.

1985/86 data

Sources: Brazilian traffickers were the major source of cocaine in Canada (30%) in 1985 for the first time. Traffickers in Peru and Bolivia were each responsible for a 25% market share, down slightly from their 31% and 32% respective market shares in 1984. Colombian traffickers accounted for 20%, compared to 18% in 1984.

Market share distribution changes reflect increased enforcement efforts in South America which disrupted cultivation, processing, and trafficking operations from the traditional core areas of Colombia, Peru, and Bolivia.

Most cocaine entered Canada by air (79% of seizure incidents); 20% came in by land.

Seizures: Sightly less cocaine was seized in 1985 (109 kg compared to 115 kg in 1984). In most areas, cocaine could be purchased in gram and, increasingly, ounce quantities. The lowest street prices prevailed in Vancouver, Toronto, and Montreal. Montreal is the principal centre of distribution.

The slight drop in seizure amounts does not necessarily reflect the start of a downward trend. The number of traffickers investigated increased to 1,942 in 1985 from 1,676 in 1984. As well, the amount of cocaine seized in foreign jurisdictions which was destined for or had transitted Canada increased dramatically to 1,168 kg in 1985 from 20 kg in 1984.

CHEMICAL DRUGS

Trends to 1988

• Principal sources for illicit chemical drugs in Canada will continue to be: domestic clandestine laboratories, particularly in British Columbia, Ontario, and Quebec; illegal importing of illicitly manufactured and diverted drugs from foreign sources; and, diversion of drugs legally manufactured in Canada.

• Outlaw motorcycle gangs will continue as one of the major organized crime threats in Canada, with emphasis on their involvement in illicit drugs. They will be active in financing, manufacture, and distribution of chemical drugs throughout Canada and are expected to continue diversifying through sophisticated money-laundering techniques.

• As psilocybin grows in popularity, traffickers will turn more frequently from the domestic, free-growing psilocybin mushroom to cultivation under controlled circumstances. The result will be larger, more potent varieties.

• Laboratories producing chemicals will represent a serious threat and environmental hazard.

• The Addiction Research Foundation in Toronto reported diminishing use of chemical drugs by high school students (**The Journal**, December, 1985). If this trend continues, abuse of chemical drugs generally may further decline.

1985/86 data

Sources: Outlaw motorcycle gangs were actively involved in the financing, manufacture, and distribution of chemical drugs in virtually every region of Canada in 1985. Diversion of pharmaceuticals from licit distribution remained a significant problem. The majority of chemical drugs (eg, PCP, MDA) are manufactured in Canada; a certain number (eg, LSD, MDMA) are imported from the US, primarily by land.

The manufacture of controlled substance analogues (**The Journal**, January, 1986) represents a serious threat: these analogues produce effects similar to heroin but can be more than 1,000 times as potent. They are currently a major abuse problem in the US and are expected to appear in Canada.

Seizures: Overall, the number of people under RCMP investigation as chemical drug traffickers increased by 10% in 1985, to 353, from 320 in 1984. The highest level of traffickers investigated in this category rose by 20%.

LSD was the favored chemical drug of abuse in 1985; the most readily available forms were blotter and microdot. Several different varieties of methamphetamine were also available, as were a number of new combination drugs.

CANNABIS

Trends to 1988

• Cannabis derivatives should constitute the leading drugs of abuse through 1988, unless foreign markets are severely disrupted by changes in climate and drug enforcement programs in source countries. Canadian drug users will continue to consume marijuana, hashish, and liquid hashish at current levels from readily available supplies provided by numerous domestic and foreign sources.

• The distribution of market share will reflect the dynamics of the marijuana trade; the progressive decrease in Colombia's share of the Canadian market will continue.

• Other foreign sources closer to the Canadian market, plus domestic cultivation, will replace Colombian supplies. Mexico, Jamaica, and the US are the most likely sources.

• Domestic production, using both the traditional outdoor method and, increasingly, indoor hydroponic growing techniques, will increase through the 1990s.

• Mothership operations on both the Pacific and Atlantic coasts will significantly determine the quantity available in Canada. Lebanese hashish will continue to be smuggled in in multi-ton cargo shipments.

• Jamaica will supply the majority of liquid hashish reaching Canadian users, with domestic production and Lebanon accounting for the balance.

1985/86 data

Sources: Domestic marijuana supplied 10% of the Canadian market; the major foreign suppliers, in decreasing order of importance, were traffickers in Jamaica, Mexico, Colombia, Thailand, and the US. Colombian traffickers' share continued to erode because of vigorous enforcement in that country as well as a shift there to coca cultivation. The loss was rapidly filled by traffickers in several countries closer to Canada: Mexico, Jamaica, and the US.

Lebanese traffickers are still the leading suppliers of hashish in Canada. They supplied 65% of the market here in 1985, while Pakistan/India supplied 30%, and Jamaica 5%. The Lebanese traffickers' ability to supply multi-ton hashish shipments via ocean-going vessels crossing the Mediterranean and Atlantic largely contributed to their maintaining their market share.

Jamaican traffickers supplied 90% of the liquid hashish reaching the Canadian market, and Lebanon and domestic production accounted for 5% each.

In 1985, 75% of marijuana arrived in Canada by land transportation, 20% by air and 5% by sea. In 1984, land accounted for only 20% of the cannabis transportation, while air and sea transportation each accounted for 40%.

Seizures: Total cannabis seizures were up 257% (to 22,940 kg) over 1984 (6,430 kg), largely as a result of two major hashish seizures in Nova Scotia (13.4 tons) and Quebec (five tons).

Cannabis-related charges changed pattern, with 12,662 people charged in 1985, a marginal decline from the 12,831 charged in 1984. Possession offences declined slightly, to 9,774 in 1985, from 10,354 in 1984; cultivation charges decreased to 177, from 192 in 1984. However, trafficking offences increased to 2,433 in 1985, from 2,014 in 1984; and, the number of people charged with importation rose to 278, from 271.

THE BACK PAGE

Students: staying out of trouble

Golobitsh

Early school success a drug-free indicator

By Harvey McConnell

WASHINGTON — Improved academic and social skills, better communication with parents, and reduced rates of misbehavior have been demonstrated in some Seattle school children in a University of Washington research project.

David Hawkins, PhD, director, Center for Social Welfare Research there, points out that previous research shows students academically and socially successful in elementary school are less likely to have problems with alcohol and other drugs, school behavior, or delinquency in high school.

What the researchers have been able to demonstrate in the Seattle Social Development Project, which began in 1981, "is that by the end of elementary school, those risk factors can be reduced by primary prevention approaches." They suggest working with parents and teachers and peers to change the social environment which young people are growing up in.

Dr Hawkins does not know if such a project will work in other school districts because longitudinal research is needed.

"But, if a school district is interested in increasing commitment to school and improving student behavior so that fewer students are suspended or expelled, then I think the program has demonstrated effectiveness."

More on kids

Page 7 and The Back Page

He told a seminar here held by the United States Alcohol, Drug Abuse and Mental Health Administration that the program now involves 11 schools through a comprehensive family, school, and peer-focused approach.

Three schools receive only a parent training program, and five schools serve as controls.

Forty-eight percent of the students are from low income homes, and 51% are from ethnic minorities.

Dr Hawkins said teachers are trained in positive classroom behavior; parents are encouraged to create an environment at home where learning is valued and is fun. Later, parents are provided with skills aimed at preventing alcohol and other drug abuse before their children start using.

They try to teach the students how to "stay out of trouble, keep your friends, and have a good time."

Dr Hawkins said their investigations have found those involved in the program have reduced school misbehavior, aggressiveness, self-reports of "being tougher" than peers, suspensions and expulsions, and student reports of drug use.

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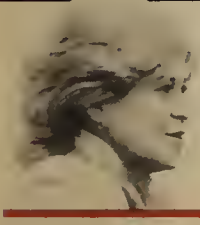
Bolivian anti-coca drive page 5

Education will be a top priority

Epp set to launch national drug strategy



Anne MacLennan reports

TORONTO — Canada's Health and Welfare Minister Jake Epp has told **The Journal** millions of federal dollars will be put into drug education, prevention, research, and treatment programs across the country in the next five years.

In an exclusive interview, he said education will be a "top priority" component of the soon-to-be-announced national drug strategy.

"I don't simply want a *Miami Vice* approach. There will always be an interdict side to life; we know that, both from the RCMP (Royal Canadian Mounted Police) and National Revenue (Canada Customs). But, the strategy should not . . . be more police in high-speed boats or high-powered cars or whatever.

"There has to be an education approach. I think every one of the drug and alcohol addiction people across the country is telling us that."

Mr Epp said the government will also set up a drug secretariat in Ottawa, sign the 1971 United Nations Psychotropic Substances Convention, amalgamate Canada's Narcotic Control and Food and Drug acts, and amend legislation to strengthen enforcement efforts aimed at removing the profits from illict drug trafficking.

The official strategy announcement is imminent (a federally-backed drunk driving campaign is also expected to be launched this month; an anti-smoking campaign was announced in April).

Mr Epp's intention is to make a joint drug strategy announcement with the provinces.

"I don't think this thing can fly if we don't have the provinces and the alcohol and drug addiction foundations with us. But, that would be our purpose. I would think it would be theirs as well."

Certainly, he said, the strategy will be unveiled here before he leads the Canadian delegation to the two-week International Conference on Drug Abuse and Illicit Trafficking (ICDAIT) at the United Nations in Vienna in June (**The Journal**, March). (Solicitor-General James Kelleher will replace Mr Epp in the second week.)

That meeting of world government cabinet ministers, called for two years ago by the UN Secretary-General (**The Journal**, July, 1985), together with increasing pressure from national and international experts, was a chief catalyst for development of a national strategy.

Essentially, it will reflect significantly increased federal commitment, particularly on the health side, to examining ways of reducing problems related to drugs — in Canada and abroad.

Driver

Epp: not Miami Vice

Almost certainly, the government will continue to be accused of mimicking the United States and/or of trying to win votes with an issue on which the provinces have done most of the substantive work.

Some observers note, however, that the federal government also deserves credit for finally tackling a traditionally politically unpopular issue and one that even unbridled optimists agree will never go away.

At the same time, there has been concern the federal commitment may not be firm enough to survive the next election.

Said Mr Epp: "The federal government and/or provincial governments and/or addiction agencies have gotten involved before; there's been a thrust, and then things have died out.

"If you take a look at my own department — in 1971/72, we had 96 people (on drug issues); I don't think I can scare up six now."

That acknowledged, however, he said: "I can't really commit anyone beyond five years, simply because of the democratic process. But, I have made it very clear to my cabinet colleagues that it has to be an ongoing thing.

"There has to be international cooperation and national cooperation. That's why we've worked so carefully with provincial governments, as well as with the agencies and volunteers."

Mr Epp anticipates the current strategy will "all be in place by the end of this (government's) man-

(See Cooperation, p2)

Intranasal, intravenous, or freebasing — all cocaine users take neurological risks

By Katherine Lake

NEW YORK — Cocaine users run the risk of a wide variety of neurological and psychiatric complications, suggests a review of cocaine-related emergency room visits at San Francisco General Hospital (SFGH).

Permanent brain damage and death can result from coke-induced strokes, prolonged seizures, and psychotic behavior leading to accidents or self-destructive acts, Daniel Lowenstein, MD, told **The Journal** at the annual meeting here of the American Academy of Neurology.

"We've seen serious neurological and psychiatric complications in first-time users, occasional recreational users, and chronic abusers," said Dr Lowenstein, chief resident in neurology, University of California, San Francisco (UCSF) Medical Center.

"The people in our series used all routes of administration — intranasal, intravenous, and freebasing. So, there appears to be no route that is safer or more dangerous than others.

"Taking only small amounts doesn't seem to be any safer than doing large doses. We've seen people who had strokes after doing only one line — about 25 milligrams."

In about half the cases of complications, the problem occurred within a few minutes to an hour after use. At the other end of the spectrum, seizures and strokes may be delayed up to 12 hours after use, the review found.

In the last seven years, emergency room records and data from the poison control centre at SFGH identified 145 neurological and 92 psychiatric complications linked to cocaine use.

After excluding patients who had taken other drugs in addition to cocaine, and those with a history of neurological and psychiatric disorders, 133 patients were included in the series reported at the meeting.

Sixty-six patients had neurological complications, and 67 had psychiatric effects. In all cases, there was either a close temporal association between cocaine use and acute complications or urine test confirmation that cocaine was the only drug taken.

The most common neurologic complication was seizures (28 patients). Six patients reported having had seizures after cocaine use,

(See Coke, p2)

Free needles in UK AIDS fight

AIDS: the needle debate intensifies page 6

LONDON — Twelve centres in Britain will give intravenous drug users clean needles and syringes in exchange for used ones.

Addicts will receive advice and counselling as well when they receive their clean needles at specified hospitals and drug advice centres. The action is part of the government's vigorous and uncompromising public education campaigns about and against the spread of AIDS (The Journal, December, 1986).

British Secretary of Health Norman Fowler said the action was taken after wide consultation with those in the drug abuse field.

Mr Fowler: "All the schemes will be closely monitored to help assess their effect on the behavior of drug misusers and the part this might play in combating the spread of infection."

INSIDE

NEWS

Briefly . . .

Survival odds

SAN DIEGO — Nicotine may promote the spread of cancer, and diagnosed patients should be encouraged to stop smoking to improve their odds of surviving, reports *Associated Press*. A study presented to an American Cancer Society meeting here adds that nicotine disrupts one of the body's built-in defences against cancer's spread. This also raises questions about prolonged use of nicotine gum to break the smoking habit, researchers say.

Snowed under

TORONTO — There's so much cocaine in this city that a recent $750,000 'bust' by police hardly made a dent in supplies. "We're snowed under with cocaine. The city is full of it," Staff Sergeant Larry Hovey told *The Toronto Star*. He adds the purity of the drug is considerably higher than in 1986, a fact which has been blamed for one death and several accidental overdoses.

All that's sacred

OTTAWA — A Nova Scotia man lost his battle with the Supreme Court here that marijuana is a sacred plant, reports *Canadian Press*. The man, who was convicted of growing the plant in his backyard, argued via satellite hook-up from Halifax that his freedom of religion was violated. His sentence — of one day — was upheld by the three justices.

No questions

TORONTO — The Addiction Research Foundation here has developed emergency money envelopes for over-imbibers who need instant cab fare. Designed to provide on-the-spot help when it's needed most, the envelope carries the message: "No questions asked."

R_x for deceased

LONDON — A doctor here filled in names of his dead and dying patients on prescriptions to feed his addiction to painkillers. The GP, who had chronic pain following a car crash, became dependent on Palfium (dextramoramide tartrate) and "went through hell" attempting to wean himself off the drug, says *Doctor*. The GP's case will be heard before the General Medical Council, which has stringent powers to restrict a doctor's right to prescribe.

Prolonging lives

WASHINGTON — The United States government has approved the sale of the first drug for the treatment of AIDS — a costly, potent chemical with serious side effects, says *Canadian Press*. The drug, to be marketed as Retrovir (azidothymidine), is derived from herring sperm in a complex chemical process. The drug will prolong patients' lives, but it is not known for how long. One serious side effect is a deterioration in bone marrow, thereby reducing production of infection-fighting cells.

Sticker scare resurfaces

False alert on LSD tattoos for kids

By Peter Unwin

TORONTO — An-out-of-date flyer containing alarming and incorrect information on a type of blotter LSD is reappearing in many parts of North America, including Toronto, Chatham, and Windsor, Ontario.

The flyer, a typewritten, photocopied sheet mailed anonymously to high schools or dropped off in day-care, community centre, and doctors' offices, first appeared about eight years ago. It warns parents of a stick-on tattoo called Blue Star . . . "a small sheet of white paper containing blue stars . . . impregnated with LSD."

Stamped on the flyer is the address of the education office of the Seventh Day Adventist church in Berrien Springs, Michigan.

Secretary of the education office, Agnes Andersen, told **The Journal** she has "no idea" who is distributing the flyer now, or why.

"We did send it around to our own (Seventh Day Adventist) schools," says Mrs Andersen. However, the education office was informed about five years ago by drug rehabilitation and police personnel that no such problem existed. Local police told her the sticker LSD scare seems to reappear every Halloween.

Staff Sergeant Larry Hovey, of Metropolitan Toronto Police's Central Drug Information Unit, says some examples of Disney figure paper tattoos containing LSD were discovered in Toronto in the late 1970s. However, "it's definitely not here now. At least, we've never seized any."

The outdated flyer claims this form of blotter LSD can be absorbed "through the skin by simply handling the paper . . . . " However, pharmacists at the Addiction Research Foundation, Toronto, say this is unlikely.

The reappearance of the flyer, combined with its alarming tone, has caused a spate of concerned calls to radio stations and drug rehabilitation centres.

In some areas, a footnote has been added to the flyer that reads, "NB: These 'stars' have been reportedly found in Windsor and Port Huron, Michigan. They may be here sooner than we think."

No such findings have been made in Windsor, says Staff Sergeant Ian Chippett, Special Investigations branch, Windsor police.

Cooperation key to strategy success

(from page 1)

date (slightly more than two more years)."

But, the five years is less than some had hoped and advised — not least, the deputy secretary of health for Australia and that country's lead minister on the Australian national strategy, which began in April, 1985.

In November, 1986, Anne Kern told a meeting of strategy officials in Ottawa that Australia had erred in not appointing one existing state (provincial) agency as a national resource and working from there.

Said Mr Epp: "There are pros and cons (on the idea of a national institute). But, because it gets into provincial jurisdiction, there is some hesitation.

"What I think absolutely, though, is that with national health and welfare as the lead ministry, there has to be a secretariat — high profile — that, a) people can know about, and that, b) can be contacted and be a coordinating body.

"That is maybe the answer to a national centre as opposed to setting up another quote, burcaucratic, unquote, operation. In fact, I have a person in mind already, to lead it."

If one national institute is not set up, will some existing programs be considered as 'national' resources and funded accordingly? That question, which is causing considerable speculation among professionals, remains to be answered.

Privately, there is widespread consensus among expert observers on one thing, and Mr Epp concurred and stressed it: the strategy is only a start, and its success is going to hang most heavily on cooperation among the disparate governments, departments, agencies, and special interest groups that will be involved.

One thread of concern at provincial levels has been suspicion of federal arrogance.

Mr Epp: "We are not trying to be arrogant. I raised some of these matters at the federal/provincial ministers of health meeting and got cooperation. I got the feeling from a number of provinces that they simply didn't have the money. There may always be some resentment; but, frankly, I am not aware of it, and I think the cooperation has been good — both ways.

"How this strategy works is going to depend on cooperation and on working it out; otherwise, it isn't going to fly."

Epp: pros and cons of a national institute

Coke complications hit neurology patients

(from page 1)

two presented in status epilepticus — severe prolonged seizures requiring pentobarbitol anesthesia for control.

Ten patients presented with what neurologists call focal symptoms, a category that includes strokes and a temporary reduction in cerebral blood flow that can cause a variety of less serious, but still disturbing, reactions. Two experienced bleeding into the brain and coma, one from a ruptured aneurysm and the other from a ruptured arteriovenous malformation.

Lowenstein: predisposed

The remaining eight patients experienced transient numbness in a limb, severe motor incoordination, or temporary loss or blurring of vision.

Headaches, varying in intensity, were the presenting problem in nine patients who described them as very painful, diminishing over a 24-hour period. One patient's headache was severe enough to require hospitalization for further evaluation. Tests proved to be normal, but pain persisted for seven days.

Nine patients had a depressed level of consciousness for which no cause other than recent cocaine use could be found. Five patients had severe dizziness; a further five had "miscellaneous" neurological reactions.

The majority — 35 — of the 67 patients with psychiatric complications were extremely anxious or agitated; two were described as aggressive by examining physicians. Twenty patients were psychotic, paranoid, or hallucinating. Four of these jumped or fell out of windows from dangerous heights; three of them needed admission for serious injuries. Suicidal thoughts were the main presenting feature in 11 patients, and one patient was severely depressed.

"We can't conclude from this study, in a scientific way, whether some people are particularly predisposed to having acute neurological or psychiatric complications after cocaine use," Dr Lowenstein said.

But, it is generally assumed by researchers in the field that some people are more susceptible than others. "One hundred years ago, Freud said in his *Cocaine Papers*, when he was using cocaine therapeutically, that there are people who have a variety of idiosyncratic reactions that can't be explained.

"Certainly, people with high blood pressure are more prone to strokes because cocaine is known to raise blood pressure severely. Also, for the same reason, people with an undiagnosed aneurysm or arteriovenous malformation might have a rupture after cocaine use."

The cause of transient focal neurological symptoms is unknown but might be caused by blood vessel spasm — either by direct action on the vascular system by cocaine or by adulterants used to cut it.

As for acute psychotic reactions, the mechanisms are not known. "It's possible some patients who appear normal have underlying psychiatric disturbances exacerbated by cocaine use."

NEWS

'Treatment, not injury, causes most chronic pain'

ACTH is being used successfully to treat addicted pain patients

By Katherine Lake

NEW YORK — Chronic-pain patients addicted to narcotics are being successfully treated with a substance that occurs naturally in the brain.

Genetically engineered adrenocortical hormone (ACTH), which stimulates production of the morphine-like beta endorphins — the brain's own natural pain killers — is being used at a Florida pain clinic.

And, the patients are being detoxified more rapidly than those treated with standard methods, Hooshong Hooshmand, MD, told **The Journal** at the annual meeting here of the American Academy of Neurology.

In successfully treated patients, pain decreases, making them less likely to become readdicted, adds Dr Hooshmand, director of the pain and seizure control clinic, Neurological Associates Pain Clinic, Vero Beach, Florida.

Hooshmand: misconceptions

"Over 80% of the patients in our study had severe depression as a result of losing their jobs and serious family problems because of their pain and drug dependence. Immediately after treatment, ACTH-treated patients had a significant improvement in depression."

Dr Hooshmand says effective new therapies are urgently needed because dependency on opiate drugs is the main stumbling block in the treatment of the common clinical problem of chronic pain.

ACTH detoxification can be done either in hospital or on an outpatient basis, with similar results. Patients with severe narcotic dependence are hospitalized and treated with intravenous ACTH for one week; outpatients are treated with the same dose of ACTH, given as intramuscular injections five days a week for two weeks. All patients also receive occupational and physical therapy, multivitamins, and psychological counselling.

"One of the commonest misconceptions in medicine is that chronic pain is caused by injuries to various parts of the body," Dr Hooshmand says.

"In some cases, this is true, but in the vast majority — 80% — of chronic pain patients, the pain is actually perpetuated by the use of narcotics. That is to say, chronic pain is an iatrogenic problem caused more by the treatment than the original injury.

Living in a sea of narcotics, doctors are overly quick to prescribe

"Unfortunately, we live in a sea of narcotics, and many doctors are overly quick to prescribe narcotics as an easy way to deal with patients experiencing pain.

"A person might have pain because of surgery, whiplash, or a back injury, for example. Natural processes in the body will usually heal it within a few weeks to a few months. But, when the patient starts taking narcotics regularly to suppress the pain, the brain — just like Pavlov's dog — becomes conditioned to responding in a predictable way.

"The brain starts to need the narcotics because these drugs suppress the release of the brain's own natural pain-killing substances."

Many studies have shown that ACTH stimulates the release of cerebral endorphins; ACTH has also been successfully used in chronic pain syndromes in which narcotic addiction is not a feature.

To test whether ACTH would work in chronic-pain patients dependent on narcotic drugs, Dr Hooshmand and colleague Farideh Radfar carried out a randomized, double-blind, clinical trial with 83 patients addicted mainly to pethidine (eg, Demerol), codeine, or pentazocine (eg, Talwin), prospectively hospitalized and given standard detoxification treatment, including anti-depressant drug therapy.

Forty-two of these patients were randomized to receive, additionally, ACTH intravenously for seven days.

In the ACTH-treated group, the average period of hospitalization was eight days, compared to 19 days for the control group. The ACTH-treated patients went back to work, on average, nine weeks after detoxification; the control patients needed 12 weeks.

Dr Hooshmand: "And, they (ACTH-treated patients) suffered significantly less depression,

"Most importantly, after two years of follow-up, the ACTH group was 40% less likely to have gone back to the use of narcotics."

The study also found that ACTH was most beneficial in patients addicted for less than two years, with pain of physical origin.

Side effects from ACTH treatment are minimal and transitory, Dr Hooshmand adds, most common being mild weight gain, mild gastric upset, and a worsening of depression during the first couple of days of treatment.

INSIDE OUT

Freezing the desolation

There I was, merely meandering up a hushed street that seemed full of peace, on a brilliant Sunday morning in spring, and I was feeling so fine I was whistling and smiling, just like in a 1940s musical.

I had lots of time before meeting my friend, I knew, as I looked in store windows at all the new clothes I intended to buy.

I had already cleaned up my place — a small joy I had discovered very late in my life — earlier that morning, cleared away a pile of domestic paperwork, and gotten a good jump on the upcoming week's office obligations.

Then, I'd whacked some tennis balls around at my club. After the match, which I had miraculously won, I had taken stock of my recent life, in a relaxed, perfunctory way, as I hummed in the shower. (*'Pretty good*, said the brief report card; *'You're getting there nicely.'*)

I kept my meandering up for several more blocks, saluting the world and inwardly ticking off its glories in my giddy way; I would have danced if I wasn't so shy.

And then, I swear I had the feeling of being jerked and yanked around a corner by something very strange; suddenly, there I was, merely amazed, standing right in front of a small apartment building I thought I had forgotten all about.

I looked up at its balconies overlooking the park across the street. I looked in at the little lobby; I looked at the restaurant next door — it had a new name, a new look, I noticed, but the marble-topped bar hadn't changed. I looked back at the row of metal mailboxes; I looked down at the new telephone books lying on the tiled floor, ready to be picked up by the tenants. Then, I saw the wino sleeping — I could hear the snores through the glass door — inside by the intercom, his unevenly bearded face buried awkwardly in the old sportscoat, and I was off and crying.

Almost two and a half years had passed since I'd allowed this building to take a seat in my mind.

It's not that I deliberately ignored it, and what it meant, or walked out of my way to avoid seeing it again. Or that I tried to obliterate it by keeping relentlessly active, busy-busy, or happy-all-the-time.

The bottles and cans formed a cathedral dedicated to the annihilation of the self

It's just that what had gone on inside its walls while I was 'living' there had been so terrifying and shameful that when I got a chance to leave it behind, it was as if I'd been propelled with tremendous force by a giant rocket booster into a new universe. Life was so different, its challenges so surprising, that I'd barely had time to catch my breath since or to reflect on where I'd started the voyage into staying straight.

But, whatever it was that had jerked me around that corner was telling me the time to take stock of this building was now, right now. So, I crossed the street to the park, where I once used to look from the alcoholic superintendent's window and go, 'Tsk, tsk' at the winos who migrated there each spring, as I reached for another drink.

And, it all came back . . . .

I remembered how my place looked, toward the end, when the ambulance driver put the key in the ignition and came to take me away that day.

I almost took a photograph of the place, after I'd returned from the hospital.

But when I looked around, really looked around — as if for the first time — I knew I couldn't click any shutter to freeze that desolation. It seemed like the work of an artist who'd gone insane trying to paint what Hell looked like.

Every square inch of grime had its own story, if only I could have remembered it; every spill on the broadloom, every scratched wall, every pile of magazines and newspapers stacked crazily to the ceiling or sprawling on the floor, every empty cigarette box, every used match and old plastic lighter, every rotting piece of fruit and cheese — ironic, about the 'food' I'd been attempting to eat then; I had malnutrition by the end — every torn bag loaded with old garbage, every dead plant, every piece of decaying clothing tossed cavalierly aside in a lunatic's haze at 4 am.

There was the devastated refrigerator, the unusable stove, the kitchen floor that stuck to the bare foot from the spilled carnage. There was the bathroom plundered and lain to waste; the shower curtain ripped off, the filthy towels lying in old bath water, the toilet top loaded with lotions vainly bought to ward off a galloping skin disease that later, miraculously, cleared when I stopped drinking; razor blades in the bowl, gum wrappers, too.

But, above all, there were all the bottles and the cans; they formed a cathedral dedicated to the annihilation of the self. They blotted this infinitely sad interior decoration; they were like a plague. They seemed, finally, to have taken on an organic life; they were exactly like the presence of an evil too powerful and terrible to defend oneself against.

There was another part of that kingdom, too: the break-in I never reported to the police, because, of course, nothing was stolen —even thieves have standards. But, the lock was broken on the front door, and I used to be desperately afraid at night, not because someone might come in intending to do me violence, rather that someone would enter and take a long stare at the violence I had wreaked.

That would have been it; I would finally have had to face my almost unbearable unhappiness and sorrow and do something about it. And, of course, I was not ready for that yet, no way . . . .

Yes, I'd felt like a fleeing refugee in that place, terrified of the knock on the door that would signal the end, not knowing that, in order to keep on living, I was the one who would have to do the knocking. I was paralyzed with fear there, like a small animal pushed into a corner by a huge guard dog, knowing if it moved an inch its throat would be shredded.

I remembered how silently I used to step around my visible, tangible monuments to alcoholism — in the living room, in the bedroom, in the bathroom, and in the kitchen — silent, deadly silent, not wanting to wake God up.

So, I thought about these things, finally, as I sat on a bench in the park across from the small building. I thought of them with the acute memory of a soldier returning to the scene of a horrifying battleground.

I wasn't meandering when I went off to meet my friend. I was running, running; and, when I saw her, I hugged her, hugged her as hard as I could.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS

RESEARCH UPDATE

PCP and suburban teens

PCP use can be quite prevalent among upper-middle class, suburban, teenage drug abusers, a study has found. The study involved evaluating PCP use in a group of 159 adolescents attending Straight Incorporated — a non-profit, drug-treatment program for middle- to upper-middle class, suburban adolescents and young adults in Washington, DC, and St Petersburg, Florida. More than half of those questioned reported past PCP use, and 21% reported using PCP from once a month to once a week; 16% said they used PCP several times a week. Intense paranoia was the most prevalent side-effect reported by 62% of the users: other consequences included serious accidents while intoxicated with PCP and having a friend suffer a serious accident or die during use. The researchers, from Straight Incorporated; the George Washington School of Medicine and Health Sciences, Washington; the Chemical/Abuse Addiction Treatment Outcome Registry, St Paul, Minnesota; and, the Children's Medical Center, University of Virginia, Charlottesville, said the results indicated "disturbing trends" of PCP use. They note age of first experience with the drug was as low as 12 years and that many of the respondents were either unaware of what the drug was when they first used it or deceived others into using PCP. While questioning if the data can be generalized, the researchers say the survey provides valuable information on PCP use among young teenagers from well-educated, upper-middle class families.

The Journal of Pediatrics, February, 1987, v.110:322-324.

Warning on khat use in West

Western physicians have to be aware of severe psychiatric problems that can develop in chronic users of khat — a plant predominately used in East Africa and the Middle East (**The Journal**, June, 1985). That's the indirect message from British clinicians who reported the case of a 34-year-old Somali woman who developed paranoid psychosis following several weeks of daily chewing of khat. The woman was admitted to a London hospital following a drug overdose and was noted to have paranoid delusions, including the belief that microphones located on the stairway leading to her apartment were repeating her thoughts. Following 12 days of treatment with trifluroperazine (eg, Novoflurazine), the woman's mental state returned to normal. She was discharged, although later she reported suffering delusions again after chewing khat. The researchers report that the patient's impression is that large numbers of the 4,000 Somalians in London use khat; they speculate that the case "is likely to represent only a proportion of the problem." The case report suggests full-blown paranoid psychosis and suicide attempts can be added to psychic dependence and personality disorders known to be caused by the drug.

British Journal of Psychiatry, February, 1987, v.150:247-249.

Strabismus in babies of drug-abusing moms

A specific eye problem is another clinical entity to which children of drug-abusing mothers appear more susceptible. A group of Philadelphia researchers discovered that strabismus is more common in this group of infants than in the regular population. A group of 29 infants of mothers attending an outpatient methadone maintenance clinic at the Thomas Jefferson University Hospital, Philadelphia, Pennsylvania, during a three-year period were studied. The infants underwent ophthalmologic examinations shortly before discharge from the newborn nursery and at regular intervals up to age five years. Seven (24%) were diagnosed with strabismus, significantly higher than the 2.8% to 5.3% incidence normal in childhood. These babies also had significantly lower birthweights than the infants without strabismus, and their mothers were receiving a higher dose of methadone at time of delivery. In addition to methadone maintenance during pregnancy, a majority of the women reported using heroin, diazepam (eg, Valium), marijuana, and/or amphetamines, as well as cigarettes. Because infants born to drug-dependent women may be predisposed to developing strabismus, the researchers conclude clinicians should be alerted "to closely following up all infants prenatally exposed to psychoactive agents. Once strabismus is diagnosed, appropriate referrals and treatment can then be instituted."

American Journal of Disease of Children, February, 1987, v.141:175-178.

Alcoholic brain degeneration

Chronic alcoholics have significantly fewer neurons in the front part of the brain than control subjects of the same age and sex, research from Australia shows. Clive Harper, Jillian Kril, and John Daly, University of Sydney and Royal Prince Alfred Hospital, Sydney, Australia, investigated earlier reports that alcoholics have less white matter in the brain than normal subjects. The brains of 22 chronic alcoholics, many of whom had suffered from complex medical conditions related to drinking, were compared with the brains of 22 controls, either non-drinkers or light drinkers. Quantitative, neuropathological tests showed the brains of the alcoholics had significantly fewer cortical neurons in the superior frontal cortex, although the number of neurons in the motor cortex did not differ greatly. However, shrunken neurons were found in both cortical regions of the alcoholic patients. The researchers said this is the first objective documentation of a phenomenon previously suspected by clinicians. They say their findings could well account for the irreversible component of white matter shrinkage caused by the death of neurons and subsequent degeneration of axons seen with long term drinkers.

British Medical Journal, February 28, 1987, v.294:534-536.

Pat Rich

Alcoholics' CT scans costly but potentially life-saving

By Katherine Lake

NEW YORK — Computed tomography (CT) scanning of the brains of patients having first-time alcohol withdrawal seizures may be useful to distinguish convulsions caused by abstinence from those caused by potentially treatable brain diseases.

However, a United States researcher says its cost-effectiveness is debatable.

"A CT scan in patients with apparent alcohol withdrawal seizures will demonstrate a significant percentage of cases with an intracranial lesion and influence decisions about the patient's management," Michael Earnest, MD, told the annual meeting here of the American Academy of Neurology.

He said there has been a lot of controversy about the use of expensive CT scanning in the evaluation of alcohol withdrawal seizures. Although his institution now routinely uses the sophisticated technology with recently abstinent, chronic alcoholics having a first-time seizure, Dr Earnest is not making a blanket recommendation that other institutions do the same.

Earnest: ethical questions

"CT scanning is a very expensive way to take care of a population that does not take care of itself. Alcoholism is unfortunately not a cost-effective disease."

Dr Earnest believes CT scanning in a population of patients he studied with colleagues is useful, since it can lead to life-saving treatment. But, he stressed the cost-effectiveness question is debatable.

"Individual physicians (treating abstinent alcoholics) have to make their own decisions about the value of this," Dr Earnest said, adding that there are many philosophical, ethical, and social questions about alcoholism that have to be considered in the total equation.

Dr Earnest and colleagues at the Denver General Hospital, Denver, Colorado, found that 6% of a population of 259 recently abstinent alcoholics, experiencing a seizure for the first time, turned out to have brain diseases, most of which were treatable.

Their conclusion is based on the results of combined data from a retrospective and prospective study, which used strict criteria for deciding which recently abstinent chronic alcoholics experiencing a first convulsion should receive a CT scan to determine seizure cause.

Only patients with no obvious cause of convulsions other than recent alcohol abstinence were included; those with known neurological disorders, infections, or head trauma were excluded.

After analysis of detailed data on the patients' clinical and laboratory examinations at the time of hospital admission and the results of their CT scans, plus other radiological procedures, the study found 16 patients with brain lesions. These included brain tumors, arterial malformations, small aneurysms, skull fractures with hemorrhage, and subdural hematomas.

Dr Earnest said clinical management in 10 cases was changed as a result of the CT scan. Depending on the nature of the problem, patients either had neurosurgery, chemotherapy, or were referred to specialists for further evaluation of their problems.

Incentive grants promote school drug education

REGINA — Saskatchewan schools are responding to financial incentives from government to promote healthier lifestyles and activities and to hold dry graduation parties.

The provincial Department of Education is providing school divisions with grants of $200 to $1,000, based on student population.

Projects emphasizing alternatives to alcohol and other drugs must focus on students in grades 7 to 9, be developed by students, and have their involvement.

More than half of the province's 112 divisions have applied for incentive grants.

The grants are intended to stimulate student projects in each division, said a department spokesman.

The Regina public school board is also offering $500 incentive grants to students who hold dry grad parties this year.

Public responds to drug info offer

REGINA — *The Regina Leader-Post* here has had to run an extra 10,000 copies of a special, 64-page supplement, *Hooked, Examining Substance Abuse*, it produced last winter.

The special report includes interviews with adolescents and adults, parents of users, Saskatchewan Alcohol and Drug Abuse Commission officials, counsellors, teachers, police, and others affected by abuse of alcohol or other drugs.

Reporters, photographers, and editors worked for three months on the publication, distributed to every *Leader-Post* subscriber last November and then to about 2,000 Saskatchewan schools.

A further 10,000 copies were run to fill requests from various groups and individuals.

The supplement was produced as a response to a community problem, "in the hope that people who read it will achieve a broader and deeper appreciation of the perils of substance abuse," said Jim Struthers, executive vice-president of *The Leader-Post*.

"Honest, I'm not a drug addict, just a hypocondriac."

Canadian rules should guide US wine urethane

WASHINGTON — Let Canada be the guide to the amount of urethane which is allowed in wines and spirits produced in the United States.

This is the call made here to the US Food and Drug Administration (FDA) by the consumer lobby group, Center for Science in the Public Interest. The Canadian government set standards for urethane levels in wines and spirits more than a year ago, banning more than 60 US beverages then above the limit.

The Center notes studies in laboratory animals have shown urethane, which occurs naturally in fermentation and distillation, can cause carcinomas and is also suspected of being a human carcinogen. The FDA found higher urethane levels in 54 of 248 wines and liquors it studied during 1986.

GILBERT
returns next month

Bolivian farmers offered $2,000 per hectare to switch

Project could slash world supply of cocaine

Heather Graham

By Gamini Seneviratne

VIENNA — Roughly 50% of cocaine supplies to the illicit world market could be wiped out if a new multi-million dollar campaign in Bolivia is successful.

Bolivia presented details of its nascent anti-cocaine campaign and won substantial support at a special meeting here April 7.

A veteran international expert told **The Journal**: "No parallel effort has been thought of before."

Foreign Minister Guillermo Bedregal Gutierrez told representatives of 20 countries and seven international organizations, convened by the United Nations Fund for Drug Abuse Control (UNFDAC) at Bolivia's request, that the "stick-and-carrot" plan would cost at least US $300 million in the first three years, just for the carrot.

The immediate response included pledges of US $115 million in the first 18 months by the United States, 30 million Deutsche Marks by West Germany (US $16.5 million), $15 million (via UNFDAC, out of $300 million pledged earlier to the Fund) by Italy, and smaller amounts from Finland and France.

The United Kingdom said it would contribute in the next budgetary year while providing training and equipment input in the short-term. Japan will assist with training. Most others promised supportive reports to their governments; but, there were also some strong reservations, notably from among the Europeans. (Canada was among the few who were silent.)

In an interview with **The Journal** later, Bolivia's under-secretary in the ministry of planning and coordination, Ernesto Machicao, said the drive was for rapid eradication and simultaneous repair of the disruptions this would inevitably cause.

The first of the campaign's four key components, he said, is to "buy voluntary eradication" of the coca bush in 60,000 of the 70,000 hectares currently cultivated, mostly in one-to-two hectare plots.

The authorities are confident farmers in five-sixths of the target area will accept a one-time gift of $2,000 per hectare (total expenditure: $100 million) and cultivate coca no more — "provided we have the stick in hand," Mr Machicao said.

The weapon will have to be wielded against recalcitrants in the rest (10,000 ha) of the eradication area, nearly all recent lowlands plantations where the yield is large, coarse leaves. These are not good for chewing, but are great for making paste and cocaine.

In the highlands, however, where coca has been grown since pre-Inca times, legal but controlled cultivation will be permitted on 10,000 ha.

Here lies one of the two main areas on which many countries have reservations. According to the 1961 Single Convention, they argue, coca is an illegal crop.

When this international statute was being drafted, Bolivia and Peru were given the option of registering reservations. This would have allowed them to go on growing coca for 25 years after the date of ratification to satisfy the traditional chewing habit medically recognized as non-addictive and probably harmless to health.

Neither country took up the option; even if they had, the 25 years is now up. Some Bolivian officials have added fuel to this particular fire by suggesting that some of the 10,000 ha to be "legalized" could supply makers of pharmaceuticals. Though Bolivia does not have these industries, exports are possible.

Such end-use, however, of an internationally illegal product may well inhibit many countries from supporting the Bolivian program, even while lauding its four components.

The second component is the establishment of a bank-like facility to promote what Mr Machicao calls "dynamic reactivation economies" in areas affected by eradication, at a cost of $150 million. Forty million dollars will go to the third component — sub-programs of regional development such as irrigation projects, health services, and infrastructure for rural development.

The fourth and smallest component, $10 million, will be for rehabilitation of Bolivian addicts and prevention of drug abuse.

Meanwhile, there is one cardinal lesson learned in some five years of fighting drugs on an *ad hoc* basis — the stick is vital too.

Whole segments of society are dependent on money from illicit drug dealing

Any doubts that may have existed in the learning process were wiped out by Operation Blast Furnace, the three-month-long project mounted last year, with US military help, against the coca processing and trafficking operations of drug organizations.

Mr Machicao invites distinction between the *campesinos* who grow coca, still treated as a legal crop in Bolivia, and those who illegally process and traffic in it. Blast Furnace targeted exclusively on the latter, he says.

The immediate result, with the drug gangs in retreat, was that the coca leaf price in the local market plummeted to 22 cents per kilogram from $2.20. Many growers began considering alternatives.

The price is now back to about $1.80 per kg, but the lesson is clear: growers will desist if the illicit buyers are attacked.

That said, however, the government is acutely conscious of the cure-can-be-as-deleterious-as-the-ailment dimension of drugs for the national economy. Both of Bolivia's major exports, tin and natural gas, are hit by declining world market prices, while the contribution from drugs has been increasing in real and relative percentage terms.

Last year, legal exports earned $712 million, while the illegal is estimated to have brought in possibly $650 million.

Apart from the number of coca growers and their families — said to total 350,000 — whole segments of society in legal occupations, from clothiers to car dealers, are in fact dependent on money circulating from illicit drug dealing.

But, says Mr Machicao, the decision to go all out against drugs has been taken "because of its enormous corruptive power, and because consumption (particularly of the more harmful coca paste) is increasing locally."

The indispensable 'stick' has not been costed yet but is likely to be at least as much as the carrot. There appear to be no doubts, among Bolivian officials, that what is needed will be forthcoming, in cash and kind, on bilateral bases.

This view seems to be shared by US authorities, but not by many others. In fact, the main European donors — notably, Norway, Italy, and the UK — are adamant that support must be on a multilateral basis.

Bolivia-US bilateral negotiations have been going on meanwhile and are likely to be concluded within weeks. Mr Machicao says his colleagues would then, on the basis of that agreed package (technical support, equipment, etc) approach European and other countries for supplementary support.

They are unlikely to find much joy. The UK, for example, though it already has plans to send a technical team to Bolivia in May and is enthusiastic about the three-year plan, was nevertheless firmly for multilateralism at the meeting.

Most donors will certainly earmark contributions for channelling via UNFDAC. The problem now appears to be coordination and harmonization of the US and other efforts to support Bolivia.

Smoking prevention basic to primary care

By Thomas Land

GENEVA — Measures to discourage smoking should be given full recognition as an important part of primary health care, concludes an advisory document from the United Nations World Health Organization (WHO).

Primary health care is one of the most effective approaches to improved medical standards in the poorest regions of the world, which have recently emerged as a battleground between the WHO and multinational tobacco companies.

Tobacco companies hope to increase their profit performance in the poor countries to offset a decline of growth in industrially developed regions.

But, cigarette smoking renders the large populations in developing countries especially vulnerable to diseases associated with the poverty belt. And, the WHO is committed to fostering policies that lead to fundamental improvements in global public health standards.

"Smoking control measures are now winning more recognition as an important part of primary health care," concludes the WHO report. "And, this trend should be encouraged."

A WHO specialist spokesman here: "It is vital that every effort be deployed to raise public awareness and to help create new health behavior patterns in those parts of the world that are now targeted by the tobacco companies.

"The emergence of new communications strategies in health matters is therefore of great significance."

Two special health risks are exacerbated by tobacco consumption in developing countries:

- Many people in the developing regions, and especially in Africa, are already at high risk from bladder cancer caused by schistosomiasis (bilharzia). Beta-naphthylamine, a substance contained in tobacco tar, can cause cancer of the bladder and the increased risks with smoking should be recognized in terms of public health administration, says the WHO.
- An estimated 90 million — or 40% of women in Africa — are anemic, and 63% of pregnant women there have low hemoglobin concentrations. Smoking reduces the oxygen-carrying capacity of the blood, which is particularly dangerous in pregnancy.

A WHO specialist: "Because their blood does not have reserve oxygen capacity, smoking by pregnant women (already) in such poor condition can further deprive the developing fetus of vital oxygen. This may lead to low birthweight and increased vulnerability to the surrounding environment."

The WHO report draws attention to the present widespread lack of legislation in the poor countries for the control of tobacco promotion. It adds: "Prohibition of tobacco advertising can serve as a symbol of government concern as well as helping to reduce blatant encouragement to smoke."

CONFERENCE

The free needle debate intensifies

FORT LAUDERDALE, Florida — Should intravenous drug users be given free sterile needles in an effort to slow down the spread of the AIDS (HIV) virus among the heterosexual population?

In Canada, freer access to needles and syringes is said, by some experts, to contribute to the low number of IV users known to have AIDS.

Free needles are not even on the political agenda in the United States, and North American public education campaigns about AIDS, especially on television, are puerile compared with those in some West European countries.

Nor are West European politicians flinching from reality. Margaret Thatcher's government is every bit as conservative as Ronald Reagan's, but Britain has officially decided to supply intravenous drug users with clean needles and syringes in exchange for used ones.

Free needles ranks with HIV testing and confidentiality as issues which have split the US chemical dependency field, as a three-hour discussion at a conference on AIDS and Chemical Dependency held here by the American Society of Alcoholism and Other Drug Dependencies illustrated. See also The Journal, April.

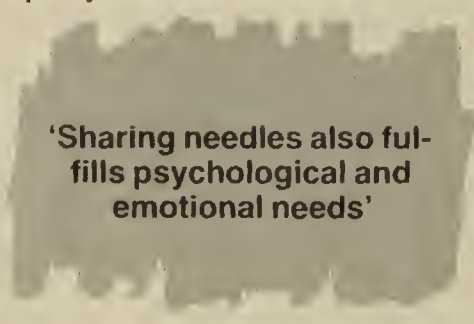
The spectre is real of a field ravaged by outside forces as the AIDS epidemic worsens and some traditional concepts are swept aside.

Contributing editor Harvey McConnell reports:

Any debate and deliberation on free needles should begin with the premise that if clean needles are legally available to intravenous (IV) drug users, the action should not in any way be construed to suggest that illicit drugs could or should be made legal, says Lori Karan, MD, associate director of the Wyman Recovery Center, part of Johns Hopkins University, Baltimore, Maryland.

She does not believe needles in themselves are good or bad: it is the behavior attached to them which is destructive. The question is whether provision of clean needles will reduce the frequency of needle sharing.

On the one hand, Dr Karan says, "I don't believe that mere legalization will affect the behavior of chemically dependent people." Needle sharing is an important element in the interpersonal trust among people in the drug-using subculture, along with increased sexuality, as they experience euphoria and after-effects together.



'Sharing needles also fulfills psychological and emotional needs'

"Sharing needles is not only a method of economy and convenience, it also fulfills psychological and emotional needs," she adds.

Needle exchange

On the other hand, there is no question there is a demand within the IV drug community for clean needles. There is evidence a number of diabetics sell their used needles on the blackmarket, and some dealers include clean needles with each drug purchase.

Dr Karan: "Most worrisome of all is the repackaging and selling of used needles as clean or new needles."

She does not favor any sort of "one-to-one" needle exchange or providing needles only to addicts waiting to enter a methadone maintenance program.

Dr Karan says that "solely teaching boiling, bleaching, or alcohol sterilization will hinder legalization (of needles) and be less effective in reducing the danger of infection."

There is a need for much greater education among IV drug users, especially in areas where the spread of the HIV virus is not epidemic at the moment. There needs to be far more treatment available, intensive counselling, and the possibility of detoxification and the use of naltrexone as a preferable alternative to extending methadone maintenance.

And, one idea might be development of a needle which self-destructs after one use.

Peter Selwyn, MD, medical director, drug abuse treatment program, Montefiore Hospital, Bronx, New York, reviewed a study of IV drug users in treatment and in detention (**The Journal**, January, 1986) which found about 40% said they stopped sharing needles. This adds to the evidence that some IV users have changed their habits because of AIDS.

But, it must be realized "the social network of using needles is very strong and must be taken into account."

Dr Selwyn says provision of free needles could be a "hook" to get people into being educated about AIDS and into counselling. This is especially true for the many disenfranchised addicts.

No questions asked

He is unaware of any evidence that increasing the availability of needles will lead to a predictable increase in the level of drug abuse. It could turn out to be true; as yet, there is no evidence or convincing argument to the contrary.

Determined opposition to the idea of free needles was expressed by David Smith, MD, founder and medical director, Haight-Ashbury Free Medical Clinics, and research director, Merritt-Peralta Chemical Dependency Institute Hospital, San Francisco, California.

Removing people from the needle scene "is the only completely safe method" to stop HIV transmission in the IV drug-using population. He believes any idea that free needles will reduce or eliminate exposure to the HIV virus "is not true and will become less and less true."

In San Francisco, however, there is already *de facto* legalization by many pharmacists: they don't ask questions when people come in to buy needles.

Dr Smith says he would like the American Medical Society on Alcoholism and Other Drug Dependencies to support the method he and colleagues at the Haight-Ashbury clinic have developed of "teach and bleach." Community workers go out among the IV drug users and try to get them to treat their needles and syringes with bleach. At the same time, the workers educate them about the risks they are running. The method is safe: some stupified addicts have even injected bleach and nothing has happened to them.

Dr Smith says the teach and bleach method is not the only model which can be used. "We can't make the distribution of needles a number one priority, and this will only reinforce an addictive pattern."

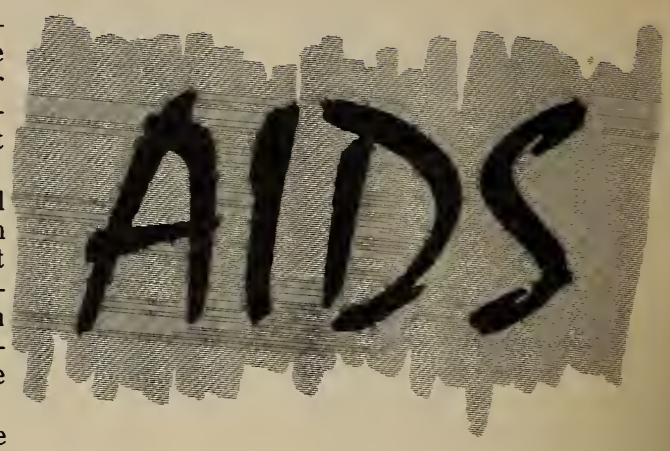
He believes the message should be hammered home that addiction is a treatable illness, "and it is possible to get out of the IV drug abuse scene and into recovery."

Provision of clean needles would be an imperfect compromise.

Robert Niven, MD, now director of the chemical dependency program at Harper Hospital, Detroit, Michigan, suggests the question should be: "What impact will the provision of sterile needles to IV drug abusers have on the prevalence and complications of AIDS? Not, though it is not an irrelevant question, what will the impact be on drug abuse.

"I can conceive it might have an adverse as well as a beneficial impact. I would submit the answer to that question is not known with any reasonable scientific certainty."

Dr Niven speculates that if free needles are provided, there may be one subgroup of IV drug users who will use them, thus reducing their exposure to contaminated blood products. There will also be a large subgroup for which it would make no difference; many of these users might be very resistant to the idea.



And, there may be a small group of people who are early-on in their addictive patterns, not yet into going to "shooting galleries," but for whom the provision of free needles might hasten involvement in the IV drug abuse scene.

Dr Niven points out that one segment of society has already made a decision: "There are entrepreneurs out there who have found a market for people who want —and, unfortunately, they are not all getting — sterile needles. At least, there is a market out there."

Dr Selwyn says evidence from Amsterdam, the Netherlands, where provision of free needles started in 1984, is that some drug abusers will change their habits because of the risks of HIV infection. There is no evidence or demonstrated markers so far that IV drug use has increased in the city. Nor is there any evidence of accidental sticks when needles are found by sanitation workers or young children.

He is concerned that any attempt to find a technically easy intervention, without a link with directed, comprehensive education; attempts to change behavior; and, provision of treatment, might be ineffective and, on the whole, not very defensible.

Dr Smith says a number of interviews he's had with current IV drug users and former users now in Narcotics Anonymous (NA) show diametrical views. Those still using drugs think not only needles but also heroin, cocaine, and amphetamines should be provided free. Those in NA hold the opposite view, saying any supply of free needles would have helped sustain their addiction.

"If you make needles and drugs free, with absolutely nothing else, you will decrease the mortality and morbidity of AIDS; but, you will increase as well the rapid delivery system to the addict population, particularly among younger people," Dr Smith predicts.

Dr Niven says issues of chemical dependency must be given consideration. "The fundamental research question to be answered from the standpoint of this virus is, 'Would the distribution of free needles have a negative or positive effect on some section of this population? And, what would it cost us?'

Grabbing a hook

"If it did have a positive impact, we would have people to treat for their drug dependency for a longer period of time than you would otherwise, because we need to remember this is a rapidly spreading and — for those who get it — fatal disease."

Dr Smith says it is no good using the "hook" mentioned by Dr Selwyn of coupling distribution of free needles with consulting, unless there is an expansion of treatment capacity. Dr Niven's view is that there is a subgroup who would not need a hook, as well as a large subgroup who would spot the hook and not come in for counselling, although it would be nice to bring them into broader treatment programs.

Dr Niven agrees with Dr Smith's contention that concern about the AIDS epidemic should not dictate every action of the chemical dependency field.

Sacrifice

"But, I submit the converse is true: we should not be so hardnosed about it that the traditional, chemical-dependency, treatment-philosophy concept of things should stand in the way of dealing with this literal threat to our society."

The chemical dependency field should give thought to some scenarios which Dr Niven speculates could be drawn up by scientists not involved in and with little knowledge of the field.

One scenario would be that that clean needles would unquestionably help diminish the spread of the virus and, at the same time, worsen the spread of drug use.

Dr Niven predicts this would produce a serious dilemma, "and I would postulate to you that a large segment of the population world 'sacrifice' the worsening of the drug-abuse problem in order to achieve a diminished spread of the virus. I don't think, though, that it will turn out this way."

Another scenario, albeit hard for those in the field to imagine, is the possibility "that some of the drugs we spend most of our professional lives getting people to stop taking might, indeed, be beneficial to the AIDS patient." It is more probable the drugs increase infectivity, but, it is just conceivable they may help some people.

Current street lore is that amphetamine use might help minimize the progression of the disease in AIDS patients.

Dr Niven: "I don't personally believe that, but one must have an open mind."

Because drug users will go to any lengths to get a needle, "even one used by 100 people before," Dr Selwyn postulates it is not out of the realm of possibility, since drugs are big business, that some pushers would distribute clean needles. They don't want "clients" dying on them.

Dr Niven points out that those who run some houses of prostitution — another big business — insist on monthly HIV testing of their 'employees.' Any found to be HIV-positive, or who use drugs, are dismissed. 'Customers' are made to use condoms.

Although he makes no endorsement, "a creative research program may be to involve dealers, because they have a vested interest in keeping their customers alive."

Niven: impact on virus?

Smith: determined opposition

Reaching back: counsellors and remembered adolescence

Constant support needed

Community vital to good teen care

By Deana Driver

REGINA — People who treat chemically-dependent adolescents must remember their own adolescenee.

"Every generation looks back at the newest erop of kids and gets nervous," but it's not so frightening if one looks at these teenagers with one's own adoleseent eyes, says David Zarek, director of the Washington, DC offiee of the Johnson Institute.

"The more you can reach the adoleseent within, the more you ean understand what's happening with kids, and the more you ean conneet with them," he told a national conference here on adolescent chemieal dependeney.

And, it is vital to make that connection with teenagers.

Treatment has a component of rehabilitation as well as habilitation, said Mr Zarek, and relapse prevention is "equated almost exactly with doing something to enhance adoleseent development."

To be sueeessful in treating adoleseents, one has to be there to infuse them with success every step of the way. If one measures sueess or failure by a single return to drugs, the attempt will always end in failure.

But, total abstinenee — instead of moderation — is the only effective way to get teens off drugs.

Mr Zarek: "If you really want kids to be successful, you have to spread a network out that will infiltrate the community."

Aftereare must be considered from the moment the adolescent is assessed, and the process has to reach into the school system for when the teen returns home.

The adolescent has to be provided with a new pool of friends and constant support when he or she needs it — not when it's convenient for the treatment centre.

Nancy Rosendahl, exeeutive director, Omegon treatment centre, Minneapolis, Minnesota, said members of the community must work together instead of blaming each other for the problem.

"Treatment happens not in the centre. It happens in the community."

Rosendahl

Zarek

She said society is more willing to fight drug abuse today, with more positive peer pressure not to use drugs and parents starting to crack down more on their children. "We're a little more conservative now than we were 10 or 15 years ago."

She said parents also have to stick to their roles as parents and keep watch on their children. "Kids will be kids, and they'll use whatever they can."

Centres need to treat the dependency itself, but that's not enough, said Ms Rosendahl. "You have to look at the other issues in their lives, and the family is a critieal one. We have to look at treatment as a process, not as an event, not as the final answer. The staff's biggest challenge is to keep expectations realistie."

Saskatchewan youth to get help

REGINA — Saskatchewan "must stay on track" with education and other programs to fight ehemieal dependency, despite severe budget eutbacks, says provincial Health Minister George McLeod.

One out of five Saskatchewan teenagers experiences problems with peers or parents because of drinking or other drug use; 4,000 teenagers are convieted of impaired driving each year in Saskatchewan, Mr McLeod, a former teacher and prineipal, told a national conference here on adolescent chemical dependency.

Provincial plans for youth treatment include the opening of the first treatment centre for youth in Yorkton, enhancement of eommunity-based treatment serviees, prevention training, and public education programs.

The conference, sponsored by the Saskatehewan Alcohol and Drug Abuse Commission (SADAC), was intended "to demonstrate our continued commitment to (provincial) Premier Grant Devine's initiatives," Mr McLeod added.

Howard Greenstein, SADAC executive director, said workers in the field must "step baek, approaeh this very personal and often deeply disturbing problem in a systematic and a well-planned way, and build on our different strengths. The public, professionals, lay people, youth, and parents must be involved in both the planning and the implementation of services."

SADAC provided grants to more than 30 community-based ageneies last year, and the funded ageneies provided direet treatment serviees to more than 1,100 people under the age of 19 years.

Schools on track with peer counselling

REGINA — Strides are being made in Saskatchewan schools in handling ehemically dependent adolescents, and peer counselling groups are a part of that advancement.

Kal Newell, a guidance counsellor at Cochrane High School here, told a national eonference on adolescent ehemieal dependency that the sehools have been conduеting alcohol and other drug education for about 20 years.

But, "we've been doing it wrong for about 18 of those years.

"We've finally come to realize we can't just give them half an hour in the health curriculum to say how bad drugs are and forget about it" (See Teachers, The Back Page).

Life skills elasses have been introduced and having students in a home room for half an hour each day helps teaehers identify behavior changes or any other problems the students may be having.

Staff have identification sheets for inappropriate behavior and some times will find students don't have drug problems, but do have family problems.

Voluntary interventions that come through peer eounselling are helpful. Mr Newell: "We get people referring each other all the time. We're not penalizing our kids now if we find some of them have to go into treatment."

Representatives from sehools are starting to visit students in detox eentres.

"That would have been unthinkable years ago. The aftercare is coming, and likely that student is coming back to our schools," Mr Newell said.

Regina has an alcohol and other drug placement committee to help get students back into classes at a level they can manage. And, three high schools here have voted for a chemical-free graduation this year.

HOWELL

The amorphous, ineffable 'it'

"Be a part of it," said my friend, Professor Bottomsworthy. He said it softly, almost reverently. Then, in the stentorian tones of a classically trained actor, he said it again and again, savoring every subtlety: "BE a part of it . . . be a PART of it . . . be a part of IT."

"Of what?" I interjected.

"It," said the professor.

"What is it?" I demanded.

"Everything you ever wanted to be a part of," he said, as a single tear formed in his right eye and triekled down his cheek. I had never seen Professor Bottomsworthy, noted academic, abject cynie, cry before.

"I'm sorry," he said, wiping the embarassing tear away with his hand. "But look here, scc for yourself; this is so bcautiful it quite overwhelms me."

He showed me the magazine advertisement that had redueed him to tears.

The ad featured a young man and woman an lounging on a white leather eoueh; behind them on the wall was a large expressionist oil in muted pastel eolors. In front of them was a large coffee-table, on which rested a television, some flowers, a glass sculpture, some bread, a semi-eirele of Brie, a wedge of Emmenthal, some green grapes, a tall glass containing iee eubes and an opaleseent yellowish liquid, and a brown liquor bottle.

Below, in bold print, was the admonition: BE A PART OF IT.

Below that, in smaller, more elegant print were the words: Canadian Club.

"What's the big deal," I asked. "The people are attraetive, their surroundings are plush, and there's an ambiguous hint of sexual aetivity to eome, sinee he's looking at her and saying, 'Shall we call it a night.' Advertising layouts like this are a dime a dozen; they sell cars, perfume, booze, you name it. So what?"

"It is not the seene itself that is beautiful. What is so beautiful about this ad, what brings tears to my jaded eyes, is the concept," he explained.

"The concept of using an ambiguous catch-phrase, such as "Be a part of it," to massage those areas of the mind concerned with aeeeptance, belonging, and social-climbing is old hat. Admen use the coneept to sell perfume, booze, cars, you name it. So what?"

. . . Some bread, a semi-circle of Brie, a wedge of Emmenthal

"You've missed the point entirely," said the professor, pointing at the ad. "Look at that young, stylish couple on the eoueh, look at their green grapes and Brie. The first thing that strikes you is that rye whisky — or seoteh or bourbon — is most definitely NOT a part of it, since the 'it' portrayed is obviously an upseale world of yuppies who sip Chablis or Californian Chardonnay.

"So you see, the beauty of this ad is not manifest in its outward appearanee, or in its surreptitious sexual message. The beauty is manifest in the underlying, cynieal eoneeit — the assumption that the ineffable 'it' of whieh we want to be part is so amorphous as to be infinitely malleable and, therefore, open to usurpation. That is what overwhelms me and brings tears to my eyes."

"With all due respeet, professor," I said, "I find that totally ineomprehensible."

"Okay, I'll take it a little more slowly. Remember the classie General Motors ad from the 1950s showing a handsome couple emerging from a car in front of a mansion and the caption: They'll know you've arrived when you arrive in a Buiek. Needless to say, the caption was not referring to the reliability of a Buick in getting you to your friends' house in time for dinnеr. In its subtle, punning way, the ad was insinuating that ownership of a Buick would announce that you had in faet 'arrived' and had become, therefore, part of the 1950s version of 'it.'

"A great ad to be sure, beautiful in the caleulated way in which it exploited elass aspirations for eommereial gain, but its beauty is that of a primitive cavc painting compared to this Canadian Club ad."

"You're losing me," I said.

The professor sighed, and continued: "Admirable though the ad might be, it was primitive in the sense that there was no attempt to usurp the 'it:' the Buiek automobile was known in the 50s as an upseale produet; everyone knew it eost more than a Chevy or a Plymouth. What is beautiful about the Canadian Club ad is the brazen attempt to usurp the 'it' we want to be part of, by plunking-down a whisky bottle where it obviously doesn't belong.

"The distiller knows it doesn't belong, knows it is not a part of 'it.' This is why the drink shown in the ad is not an honest whisky drink, it is some sort of whisky and orange juice coneoction. The previous ad in the series showed the female yuppie ensconced in a chrome-and-leather chair sipping some sort of rasberry colored drink.

"Fruit juice — good old healthy fruit juice — is obviously considered the key to the hearts and minds of the Porsehe and Perrier crowd. Or more to the point, to the hearts and minds of those aspiring to bc part of the 'it' they think the Porsche and Perricr crowd represents. As I said, the coneept brings tears to my eyes. This substitution of one icon (the whisky bottle) for another (the white wine bottle) is a masterstroke of merchandising legerdemain."

"And you think people will buy it?"

"Of course they'll buy it. That's the beauty of it, that's what brings tears to my eyes.

"In the 1950s, the Buick was just a Chevy with three little extra pieces of ehrome on the fenders; those little pieees of ehrome eost pennies to make, hundreds of dollars to buy. But many people bought Buieks.

"Remember what P.T. Barnum said: 'No one ever went broke underestimating the intelligenee of the American publie.' Well, as a corollary to that time-tested axiom, I would add that no one ever went broke preying on the inseeurities of those who want to 'Be a part of it.'"

By Wayne Howell

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Warding off the crash

True portrait

The article by Joan Hollobon on our program for early-stage problem drinkers, Warding off the crash: a success story (January), initiated many requests for the "self-help" manual that we are using to aid treatment.

Such requests are principally from addiction counsellors working in various parts of Canada and the United States.

We were extremely pleased with the article's portrayal of our approach to treatment. However, there are several important points that I wish to clarify to avoid confusion among your readers:

- the manual is at present under evaluation, and it will take about two years before we know how effective it is in aiding therapists;
- although oriented toward the teaching of moderate drinking, the manual can also be used to attain a goal of abstinence; and,
- clients of our program are recommended abstinence as a goal if there are contraindications to moderate drinking (eg, high level of alcohol dependence, medical or psychiatric problems, low social stability, previous history of alcoholism treatment, lack of support from family or peers, and client's preference for abstinence).

Martha Sanchez-Craig, PhD
Addiction Research Foundation
Toronto, Ontario

Wrong on AA

As a recovered alcoholic and member of AA (Alcoholics Anonymous) who has never before felt the need to defend my fellowship, I cannot allow the article by Joan Hollobon (January) to pass without comment.

Why do writers for **The Journal** always feel it necessary to mention AA in their controlled drinking articles, particularly when they indicate they know little about the program (or do they)?

For example, no one in AA stops drinking for a lifetime — only for *today*. I suspect it is not the unscientific, mystical aspect of the program the writers find repugnant, but rather the implicit acknowledgement there is no "scientific" cure for the illness, that there can be no independence without dependence, just as there is no joy without sorrow, night without day, etc in a bipolar universe.

Were Joanna (who was featured in the Hollobon story) able to accept her problems, she might find such psychic relief that she would no longer need to seek escape in chemically induced consciousness and ultimate unconsciousness (blackouts).

It is astounding that Dr Martha Sanchez-Craig can include someone who has suffered a blackout in her intervention program for *early*-stage, problem drinkers.

The medical profession considers the blackout as an infallible indication the patient has crossed the invisible line from normal to abnormal drinking, even though some such people can achieve controlled, moderate drinking for limited periods of time.

To become an alcoholic, one does not have to drink for 10 years, or in large quantities. This is particularly true of women who are often beyond recall in a few short years. The idea we abnormal drinkers can control our drinking is an obsession many of us pursue into insanity and the grave.

I would also point out to Dr Sanchez-Craig that non-alcoholic drinkers have little trouble in giving up liquor entirely if they have good reason.

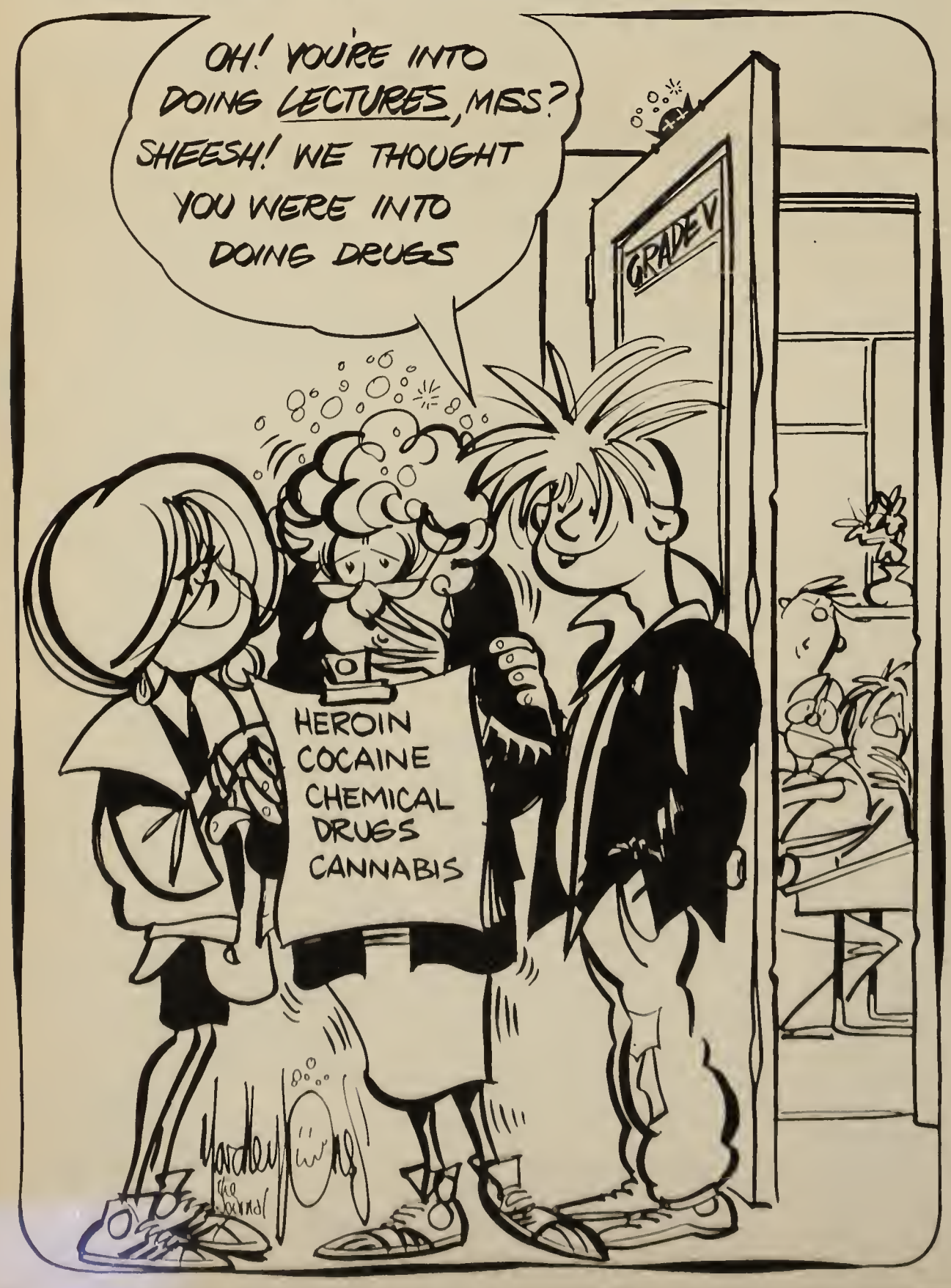
If outpatient counsellor Carole Bush prefers the word "urge" to "craving," she is on dangerous ground by word-playing and looking for an easier, softer way to deal with a life-threatening "habit."

Ms Bush states she doesn't find the word alcoholic helpful. She should survey our members (almost 2,000,000) and their families who have found that the true and honest use of this definition has enabled them to live happy, wholesome, spiritual lives.

I fought a mighty battle against acceptance of my alcoholism, including psychiatric wards, detoxification units, counselling, etc, preferring, finally, to be termed insane rather than alcoholic.

But, now I can look at the debris of my past (lost family and home, skid row) and thank God and the AA founders. It was only when I could say that which Ms Bush doesn't find helpful, and thus accept my limitations, that I began to recover.

Mari G.
Don Mills, Ontario



Interesting

On the Back Page (January), the early intervention program was outlined by Joan Hollobon.

I am very interested in learning more about this program and would gratefully receive any materials and information Dr Martha Sanchez-Craig would be willing to share.

Should the chemical dependency counsellors in this region decide to use the manual, I would be willing to provide feedback.

Please note we are located in a large rural area, in which there is a high unemployment rate, in some areas up to 80%. Thus, our client base is very much unlike the participants in Toronto.

Sheldon Brown
Regional administrator
Alcohol and Drug Dependency Commission of
Newfoundland and Labrador
Corner Brook, Newfoundland

Fascinating

The article, Warding off the crash: a success story (January) was fascinating. We'd be very interested in trying to establish such a program here at the A-Center in Racine, Wisconsin.

Could you send information on how it was promoted, and, most of all, on the essential elements?

E. W. Belter
The A-Center
Racine, Wisconsin

Sensible

The report of Dr Martha Sanchez-Craig's program concerning defensive drinking (January) was very interesting to me.

I work in a substance abuse treatment centre and would appreciate any information Dr Sanchez-Craig may be willing to share.

I do agree that the notion makes a great deal of sense. I am particularly interested in it in connection with treatment of people found guilty of driving while intoxicated, who give no indication of consistent alcohol abuse.

Philip H. McAvoy
Staff therapist
Terros
Phoenix, Arizona

(Ed note: Dr Sanchez-Craig has responded to each reader's query.)

Drug testing:

What the lab can — and can't — do

By Bhushan Kapur *

TORONTO — As interest inereases in employment-related drug testing, the interpretive skills of analysts, and the techniques available to them, continue to evolve. In the past five years, development has been signifieant; refinements continue to be introduced almost monthly.

Still, of questions asked of toxicology laboratories, more ean't be answered than ean.

Today the most common questions — from employers, but also from employees, who want to know their limits — are: how much drug was taken and when? For how long after use will the drug screen give positive results? And, what is the cause of false positives and false negatives?

Key to finding the answers is an understanding that after a drug is used, a number of events — most of them simultaneous — take place.

Generally, there are various routes of drug administration: oral (eg, drinking alcohol), intravenous (eg, injecting heroin), and inhalation (eg, smoking marijuana, snorting coeaine, or sniffing glue). Drugs taken orally are usually the slowest to be absorbed, whereas fastest absorption follows the intravenous route.

The absorbed drug enters the bloodstream and is rapidly distributed to tissues; the drug's chemieal characteristics dictate what happens next. Some drugs are highly fat soluble and are thus deposited in the fat tissues; the amount stored depends on the amount and the duration/frequency of use. An example is delta-nine-tetrahydroeannabinol (THC), the active ingredient in marijuana, which is highly fat soluble.

For the fat soluble drug, only low levels ean be found in blood. Blood levels fall rapidly as the drug is being distributed.

Peak and decline

Studies show THC levels peak and start to decline halfway through a joint. Consequently, blood analysis for THC will be positive only for a short duration.

Aleohol, on the other hand, is not fat soluble and is distributed in the total body water. Sinee blood is mostly made up of water, high aleohol levels can be found.

Generally, the lower the levels, the more sophistieated the laboratory needs to be.

Absorption and distribution are followed by elimination.

The liver is the major detoxifieation centre in the body; as blood circulates through this organ, drugs are metabolized or broken down. The metabolites are then excreted into the urine through the kidneys.

This detoxification process has the potential to produee active or toxic metabolites. Drugs deposited in fat tissues are slowly released into the bloodstream and metabolized.

Time required for levels to decline by 50% is often referred to as the elimination half-life of the drug; some drugs have longer half-lives than others.

Great variations

All of these processes, taking place simultaneously, are influenced by a variety of factors. Age, sex, physical, and clinical status of a person have a profound effect on a drug's half-life. A compromised liver, concurrent presence of another disease, or another drug, can enhance toxic effeets of a drug by slowing down the elimination process. In some clinical conditions, this process may be speeded up. Thus, it is not surprising that great variations are found in the half-lives of the same drug.

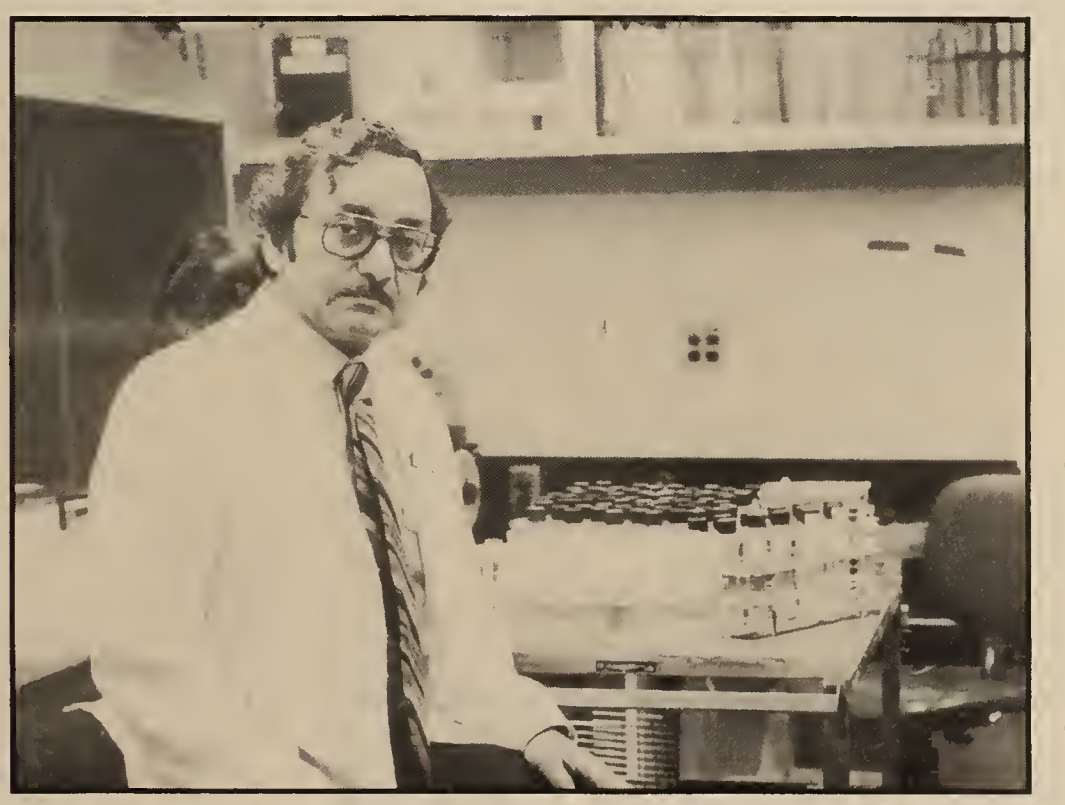
Approximately six half-lives are required to eliminate 99% of a drug. For example, cocaine's half-life is short (2½ hours), thus 17½ hours are needed for elimination. Phenobarbital's half-life is long — 80 hours — 480 hours or 20 days are required to eliminate 99% of the drug.

Since the absolute amount of drug can be very small, the seleetion of the appropriate body fluid for analysis is important. This, in turn, affeets the laboratory's ability to identify the drugs present in body fluids.

Blood and urine are the most eommonly used fluids in drug analysis. Each has advantages and disadvantages.

Blood is obtained by an invasive procedure and is available only in small quantities. Urine is available in larger volumes, requires a non-invasive procedure to collect, and is easier to obtain. Levels in blood are low. Larger available volumes and the presence of the drug's metabolite make urine the sample of ehoiee for most drug analysis.

A laboratory's ability to identify a drug depends on the *absolute amount* of drug present in the fluid being examined. This depends on how much and when the drug was taken. The time span between drug intake and specimen eollection dictates how much drug is left in the body. Drugs with a longer half-life remain in the body for a longer period.



Kapur: even the least effective test is 95% to 98% correct

Methods

There are two eommonly used methods in a toxicology laboratory: immunoassays — radio (RIA) and enzyme (EMIT) — and chromatography, whieh ineludes thin layer ehromatography (TLC), gas ehromatography-mass speetrometry (GC-MS), and liquid ehromatography (HPLC).

Both **RIA** and **EMIT** are very sensitive primary screening methods — have low detection limits — and are based on antibody-antigen reactions.

Specificity for both methods is not very high; substanees whieh have similar chemical struetures also cross-react and give a positive reaction. The EMIT or RIA methods for cannabinoids give a positive result with most of the metabolites of THC.

On a scale of 100, these tests give results which are 95% to 98% eorreet; correct drug identification is made. The list of drugs that result in a *false positive* is small.

Addition of detergents (soaps) or common salt will interfere with some of the immunoassays. Generally, these interferences result in *false negative* answers. But, recent improvement in reagents has alleviated this concern.

Urine drug assay kits, for most drugs, have been available for some time. Quantitation of drugs — drug level — in urine samples is generally not done.

If you took blotting paper, put a drop of ink on it, and held the tip of the paper in water, you would observe that the water rises. If you continue the process, given the right conditions, you would find the ink spot separates into a multiple of spots of different eolors. This process is called chromatography.

There are three types:

- **TLC:** This method requires extensive sample preparation and technical expertise. In expert hands, it is inexpensive and very powerful. A large number of drugs can be screened for at the same time; cocaine, amphetamine, and opiates can be done in one sample preparation, although cannabis derivatives require a separate preparation.

In identifying positive TLC spots, the technologist looks for the metabolite pattern. Combining different TLC systems results in a high degree of specifieity. Interpretation of results is subjective, hence the training of the analyst is erucial.

- **GC-MS:** This is a combination of two very sophistieated technologies — gas chromatography (GC), and mass speetrometry (MS). GC physieally separates the eompound, and MS fragments it so that a fingerprint of the chemical is obtained. Sample preparation is extensive.

Although both methods ean be used individually, they are used in tandem; the combination is regarded as the *gold standard*. All of the above drugs ean be identified in any body fluid. Assay sensitivity can be enhanced significantly by treating the test fluid with reagents, prior to the analysis.

- **HPLC:** This is similar to GC but takes advantage of spectroscopic or electronic characteristics of the chemicals.

Sample preparation for HPLC is less extensive; this method also results in high specificity.

The order of specificity (ability to effect a 100% correct identification) would be, beginning with the best: GC-MS, HPLC, TLC, and EMIT/RIA. But, even the least effective is 95% to 98% correct.

Excepting GC-MS, which is already a combination of two methods, results should be confirmed by a different method. To achieve the extra 2% to 5% accuracy, almost any combination of the above methods is acceptable.

The most common combination used in employment-related drug screening is EMIT/RIA confirmed with GC-MS.

Sensitivity of the laboratory method will result in either a positive or a negative answer. If the absolute quantity of drug present is small enough that it is beyond the analytical method's detection capability, a *false negative* result will be obtained.

A negative urine sereen can thus be interpreted as: the drug is not present, or the drug is present in such amounts that it is beyond the detection limit of the method used.

Method sensitivity

Sensitivity of method can be enhaneed by analyzing for the metabolites. Heroin use, for example, is determined by the presenee of its metabolite, morphine. Increasing the speeimen volume used for analysis, or treating it with chemicals, can also be effective.

Such procedures can make laboratory methods very sensitive. Studies at the Addiction Research Foundation, Toronto, show one, five-milligram dose of Valium (diazepam) can be detected for three to four days. The sensitivity can be inereased so the same dose can be detected for 20 days.

These high sensitivities make the interpretation of *when* the drug was actually used very difficult. Larger amounts of drug intake would make this method almost uninterpretable.

Drugs which are highly tissue-bound (eg, THC), are released very slowly. Depending on the amount stored in the tissues, the time varies considerably. Thus, the drug's metabolites are deteetable for a long time in the urine. In the case of THC, studies show these ean be identifiед in the urine for 20 to 40 days after last use.

Another faetor affeeting detection is dilution, which may happen if the client has eonsumed large amounts of fluids prior to obtaining a sample for analysis. Although the absolute amount of drug/metabolite excreted may be the samc during a period of time, the final concentration per millilitre will be redueed in dilutcd urine and may give a *false negative* result.

Acidity of the urine may effeet the excretion of the drug into the urine. In some eases, elimination is enhanced; in other cases, it is reabsorbed. This effect of pH in urine is carefully exploited in treating some drug overdoses.

Generally, immunoassay teehnology is used in preliminary analysis, giving a presumptive positive which should be confirmed by a different method.

A *confirmed* positive finding implies just that — that the drug was used in the immediate past (hours/days).

It is not possible with a urine test to infer from a positive finding how much, when, or how the drug was consumed.

Skills refined

Although today's teehnology can accurately determine the presence of a drug in body fluids and what drug it is, it eannot determine how much was taken, when, or how it was consumed. For example, poppy seeds may show positive on tests for opiates and not be a false positive, because some poppy seeds may be contaminated with morphine derivatives. Similarly, innocent eonsumption of coca tea has resulted in a positive test for cocaine.

As the experts refine their interpretive skills, it's possible one day they will be able to answer more questions.

However, the answer to one may continue to elude them: it's the one about how much drug was consumed. Even with alcohol, the answer to that question is still, at best, speculative.

**Dr Kapur, D Phil, is director, Clinical Laboratories, Addiction Research Foundation, Toronto.*

NEWS

GPs should see alcohol as routine health hazard

By Terri Etherington

LONDON — General practitioners should make questioning and intervention for alcohol use as routine a part of their practices as blood pressure screening or pap smears, says a report from the Royal College of General Practitioners here.

And, a full understanding of the role of alcohol and the risks and costs to society "cannot be based on any purely medical model.

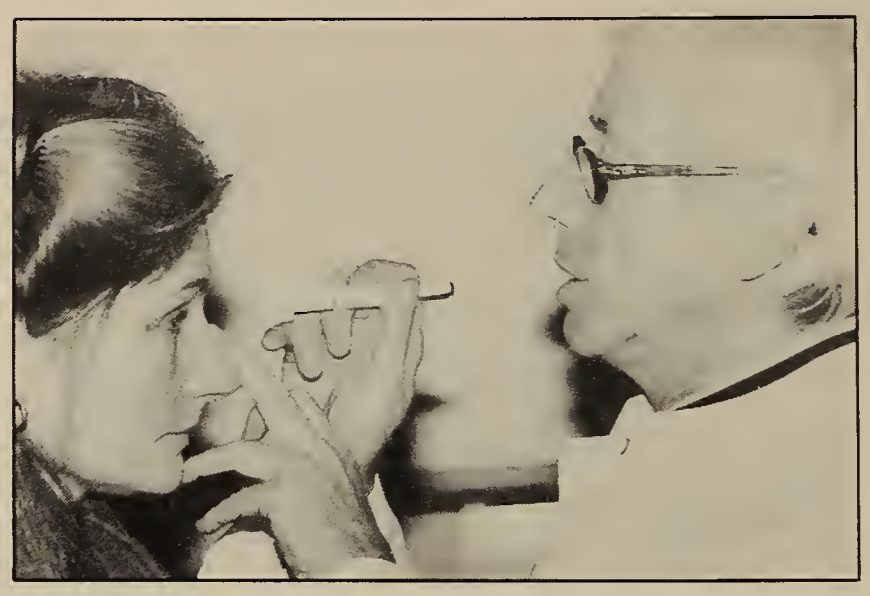
"Doctors need to change their way of thinking from alleviating, palliating, and perhaps curing damage already done, to anticipating possible harm and, by education, preventing it."

The report, prepared by a working party of the College, emphasizes the need for a multidisciplinary approach within the general practice, involving other members of the health care team.

Moderate drinkers, the team says, not only make up more of the GP's caseload than problem drinkers, but also represent more "harm" from alcohol use in the community.

"We strongly recommend that general practitioners look at alcohol as a hazard to health which needs attention no more and no less than smoking or raised blood pressure and that their daily consultations, their preventative work, and perhaps most important of all, their record systems and notes reflect this view of alcohol as a risk factor and an agent needing to be on the agenda for action just as much as taking a cervical smear or prescribing an antibiotic."

A confident and optimistic attitude toward the problems of alcohol abuse among GPs can be developed through increased education and training, at undergraduate, postgraduate, and continuing education levels.



Regular consultation: anticipating alcohol's harm

As a benefit, the report points out, knowledge and skills learned to deal with alcohol abuse can be applied to other conditions (drug abuse, over-eating) where lifestyle, personal choice, and behavior patterns are important.

The working party also urges GPs to use and support other community groups working in the field and to "seek to influence policy makers at all levels, so that the social environment would encourage lower levels of consumption."

The report examines consumption trends, reasons for drinking, harms and risks associated with alcohol, and recommends detailed strategies for recognition, assessment, and intervention. A drinking diary and prescriptive advice to "cut down on drinking" are two strategies for intervention.

Current education of GPs, the working party says, is "clearly inadequate" and piecemeal, based on a predominantly medical model. They recommend instead a more comprehensive program under the aegis of general practice or family medicine, which would be a "natural extension of the multidisciplinary work already existing, emphasizing epidemiological and sociological aspects, and accepting the concepts which soften the borders between the 'normal' and the 'abnormal.' "

Drinkers eluding emergency staff

By Paul Szabo

CARMEL, California — Emergency room personnel are not able to deal with the alcohol problems of intoxicated patients, say researchers from the University of Colorado.

They have no complaints about how physicians and nurses deal with the physical complaints of intoxicated patients in emergency rooms. But, they say emergency personnel do little to deal with problems associated with patients' drinking, like alcoholism or related psychiatric disorders.

The study was presented here by D. Terry, MD, at the annual meeting of the western section of the United States American Federation for Clinical Research.

Dr Terry said alcohol use and trauma have been linked and several studies have found the prevalence of alcoholism in emergency room patients ranges from 13% to 37% (**The Journal**, March).

Because the emergency room is "an ideal setting to identify and refer alcoholics who are at risk for alcohol-related injuries," the researchers decided to determine what sort of job their own university-based, teaching hospital was doing.

In the study, a retrospective chart review was done for 153 patients, presenting in the emergency room between May and July, 1986, with recorded blood alcohol levels (BALs) above 0.10%. Medical notes and any psychiatric notes were recorded as were laboratory results of any tests performed.

Patient demographics, chief complaint, and circumstances of admission as well as diagnosis, type and number of treatments, and medications given were reviewed.

Approximately three-quarters of patients in the study were male. The mean age of all subjects was 34 years, with a range between 16 and 78 years.

The patients tended to be quite intoxicated, with a mean BAL of 0.25% and a range between 0.11% and 0.56%.

Almost half of the patients presented at the emergency room because of trauma, with assault responsible for half of these cases, and motor vehicle accidents for another quarter.

On average, each patient received five tests, Dr Terry said, and 75% of them received at least one type of medication or treatment.

Dr Terry: "Our patients were thoroughly tested and adequately treated from a medical point of view."

In fact, more than half of the patients received intravenous thiamine as a precaution against Wernicke-Korsakoff syndrome, a rare type of alcohol-induced mania.

In contrast, Dr Terry said, physicians talked to patients about their abuse of alcohol in only 17% of cases, and in only 12% of cases were patients asked about behavior such as depression, anxiety, violence, or suicide.

Despite the presence of a 24-hour, psychiatric-care program in the hospital, only 3% of the patients had an on-site psychiatric evaluation. However, 17% were referred to a psychiatrist, and 10% were referred for treatment of alcohol abuse.

Overall, the study found that while more than half of the patients were referred to a medical clinic, surgical clinic, or to an emergency department for further care, only 21% were given a referral to an alcohol treatment program, mental health facility, or for psychiatric treatment.

Emergency: ideal setting to identify alcoholics

Informed staff make hospital program work

TORONTO — How comfortable hospital staff are in dealing with alcohol- and other drug-abusing patients, and the knowledge that their intervention can work, are often the main predictors of success of a general hospital assessment/intervention program.

Cooperation between hospital staff and specialists in addictions can provide staff training and education needed to bridge the wall of resistance often encountered among already-busy, health care personnel.

At Mississauga Hospital, Mississauga, Ontario, cooperation came in the form of a joint assessment/intervention program with the hospital's social work department and Ontario's Addiction Research Foundation (ARF).

Social workers were trained by ARF staff in the use of assessment tools and crisis intervention techniques.

As a result, says Jeanette Pieczonka, director of the hospital's social work department, social workers are not only identifying more patients with problems, but also are more comfortable with alcohol- and other drug-abusing patients and more confident they are doing some good.

Social workers' direct service time devoted to abuse problems jumped to 7.8%, from 2.6% two years earlier. And, Ms Pieczonka told a conference here: "They reported they are not nearly as reluctant to get involved with an alcoholic patient as (they were) earlier. They know the lingo; they know how to broach the topic, probe for sensitive information, and confront incongruities. They have largely abandoned a sense of helplessness about effectiveness."

Ms Pieczonka admits the department approached the cooperative venture with "collective cold feet . . . and deeply imbedded reservations."

At the same time, however, hospital staff "were frequently encountering difficult, challenging, and resistant cases with little or no specialized expertise, with cynical attitudes, and with no place to refer people to."

Participation in the program helped change those negative attitudes.

Pieczonka: collective cold feet

ARF service award to Sister St Patrick

Sister St Patrick

TORONTO — Sister St Patrick Joyce has been awarded a community service achievement award by the Addiction Research Foundation (ARF) here.

The award for a lifetime of work devoted to the care and counselling of chronic alcoholics and their families was presented by ARF president, John Marshman, PhD, at an ARF-sponsored conference on addiction intervention in hospitals.

Sister St Patrick, director of St Joseph's Hospital Detox Centre in London, Ontario, "first began to voice her concern for alcoholic patients and to develop a unique and very personal approach to helping them" as a student nurse at St Joseph's Hospital in Chatham in 1942, said Dr Marshman.

"After entering religious life in 1945, she maintained her commitment to serving individuals and families who are hurting because of alcohol and drug problems . . . and has provided, within her religious community, a constant focus on the needs of the chronic alcoholic."

Sister St Patrick is also the founder and director of St Stephen's House in London, a recovery home for alcoholic men; a founding member of Westover Treatment Centre in Thamesville; and, has been an invited participant in the Canadian Auto Workers training program for employee assistance programs.

She has also collaborated with the ARF on many projects, including documentation of the need for alcohol and other drug services within general hospitals in the 1960s, addressing drug problems among youth in the 1970s, and was a pioneer in Ontario's non-medical detoxification program.

Cigarettes are 'knot on' in Ireland

By Karen Birchard

DUBLIN — Ireland held its first no-smoking week, dubbed National Knotout, to coincide with the beginning of Lent.

The week started off on Ash Wednesday because the organizers hoped to tie the campaign to traditional Lenten sacrifices.

In Ireland, the no smoking symbol is a cigarette tied in a knot; this has produced a series of puns aimed at smokers . . . "Knot tonight, nicotine," "Put a knot in it," and "It's knot on."

The National Knotout was organized jointly by the health education branch of the Department of Health, the Irish Cancer Society, and the Irish Heart Foundation. Harry Crawley, director of the health education branch, said the deadly dangers of smoking are not being highlighted by the Irish media.

He grabbed headlines here when he told a news conference the total number of people who have died from AIDS in Ireland is less than half the deaths each day from smoking-related diseases.

More than 5,000 people die from smoking each year. Many Irish smokers are heavy smokers, using more than 20 cigarettes a day; only 20% smoke low-tar cigarettes with the majority smoking middle tar brands.

In recent years, the Irish government has taken steps to restrict cigarette advertising and publicity. All radio and television advertising of tobacco products, along with outdoor billboards, is banned. As a result, the only tobacco advertisement appears in adult publications; it is banned in publications — including imports — aimed at those under 18 years.

Those print ads that are allowed can only include a picture of the cigarette packets, brand name, the corporate name or emblem, and a text referring to quality. A health warning must be prominently displayed.

The Irish minister of health also controls the amount of money cigarette companies can spend on advertising and sponsorship.

Irish cigarettes

Court clears parents

DUBLIN — A cheering crowd greeted five members of an anti-drug group as they left the Circuit Criminal Court here after being cleared of forcibly entering and damaging the home of an alleged drug dealer known in Ireland as "Ma Barker."

The five men are members of Concerned Parents Against Drugs, and their five-day trial arose out of an incident that took place in October, 1985. The organization had staged a protest outside the Dublin home of Marie Nolan (Ma Barker).

Anti-drug protesters kept a vigil outside the alleged drug dealer's home for several nights before 21 people entered the house, barricading themselves in an upstairs bedroom.

The police had to break down the door and subsequently arrested some of the protesters.

During the trial, Mrs Nolan said there had never been drugs in her home; she denied there was always a fire burning in the house to dispose of drugs in case of a raid. She said she had not given any of the protesters permission to enter her house.

Mrs Nolan told the court that at the time of the protest, eight of her 12 children were living at home; she claimed more than $50,000 damage was done to her home.

Caribbean may open bank records

By Thomas Land

LONDON — Caribbean countries who are also Commonwealth members are expected to grant international narcotics investigators permanent access to banking records of drug-smuggling syndicates.

The united approach to the escalating illicit drug trade emerged during a recent conference in Jamaica.

The meeting, held in secret, involved senior envoys from Ottawa, Washington, and London as well as various Caribbean capitals. The envoys expressed alarm at the extent to which many Caribbean islands are used as staging posts in the illegal transport of drugs from Latin America and elsewhere to Canada and the United States.

The traditional secrecy painstakingly observed by the banks of the region has made them into convenient tools for laundering profits from the drug trade (**The Journal**, November, 1986).

But, the smugglers' dependence on discreet as well as reliable and sophisticated financial services to facilitate their transactions may prove to be the weakest link in their entire operation.

Barry Rider, an eminent international lawyer in charge of the commercial crime unit of the London-based Commonwealth Secretariat, defined the size of the problem: "We are, in this region, dealing with jurisdictions which have already been so deeply penetrated by organized crime that you cannot really trust or have confidence in their institutions."

That means, he says, that "in some countries . . . one is dealing with a criminal state."

The Jamaica conference involved seven independent Caribbean countries plus several dependent territories administered from London, including the Turks and Caicos Islands, just north of Haiti. The Turks and Caicos government was suspended by Britain last year following conviction by a Miami, Florida court of two of its senior ministers on drug trafficking charges.

Before the imposition of direct rule by Britain, the islands' government, London, and Washington entered into an exploratory accord providing access for international narcotics investigators to the financial secrets of drug dealers using local banks.

A crucial clause in the agreement committed the governments to proceed with a wider law enforcement treaty if the original arrangement works. It worked well enough to bring down the Turks and Caicos government.

The Commonwealth initiative could emerge as an important focal point of the United Nations' global conference on drug smuggling and drug abuse to be held in Vienna in June (**The Journal**, March).

The initiative also follows a recent Commonwealth summit conference held in the Bahamas — a big trans-shipment centre for the illegal drug trade — during which several participants called for the execution of convicted traffickers.

'A near hopeless job'

Israel launches national anti-drug drive

JERUSALEM — President Haim Herzog kicked off Israel's first national anti-drug drive here with a five-hour exchange of opinions and information in Beit Hanassi (the President's Residence).

The meeting was attended by a cross-section of those in the field: police, the district attorney's office, educators, health and social welfare officials, and volunteers.

It's estimated Israel has about 200,0000 occasional or fairly regular users of drugs, with hashish being the most prevalent drug.

Of an estimated 30,000 addicts, about half are on hard drugs (some 7,000 on heroin). And, only about 7% of them have applied for help.

However, some 4,300 (a 45% increase from 1985) are on drug substitutes, such as methadone. The number of deaths attributed to drugs in 1986 stood at 52, a 20% increase from 1985.

Police estimate 90% of the drug smugglers and traffickers are not caught since addicts rarely cooperate with the police; and, this high incidence of "safety," plus the astronomical profits made in drug trafficking, make the fight to wipe out drugs a near hopeless job.

Canadian money aids Pakistan poppy plan

VIENNA — Money raised by Canada, the United States, and Western Europe and channelled through the United Nations Fund for Drug Abuse Control (UNFDAC) will be used to destroy illegal opium poppy crops in the North-West Frontier province of Pakistan.

Pakistani opposition politicians claim the defoliant chosen for the aerial spraying operation is a chemical agent likely to poison the environment, contaminate food crops, and lead to the birth of deformed babies.

However, the government quotes expert medical testimony supporting claims the program would do no harm to human life.

The operation is intended to stop the export of inexpensive and high quality Middle East heroin flooding the West. Canada, Britain, and Italy recently made a series of grants totalling $10.5 million to UNFDAC here, and the US has made two contributions of $5 million (Cdn $6.6 million) each.

Giuseppe di Gennaro, UNFDAC executive director: "These contibutions are to be used for rural development activities in support of the Pakistani government's special program to eliminate opium poppy cultivation."

Aerial spraying of the vast poppy fields in the North-West Frontier province — the world's richest current source of heroin — has been advocated with increasing impatience by the Western lobby. Pakistan has acquiesced, reluctantly, to such a radical solution in the semi-autonomous province and only after the failure of lengthy attempts to persuade tribal growers to switch to alternative crops voluntarily.

Pakistan's reluctance to spray the poppy fields has been due not so much to its concern for the environment, as to its fear of antagonizing the politically volatile Pathan tribes of the province. Their temporary loyalty, traditionally available to the highest bidder, is much prized by opposing forces in the war in neighboring Afghanistan (**The Journal**, April). But, the dramatic recent increase in their heroin exports to the West — an indirect result of the war — has provoked mounting pressures for action which Pakistan could no longer resist.

INTERNATIONAL

Liquor industry joins health groups on ad rule

By Pat McCarthy

AUCKLAND, NZ — A decision by the state-owned Broadcasting Corporation of New Zealand (BCNZ) to clear the way for liberalized liquor advertising on television and radio has encountered widespread dismay here, even from within the liquor industry.

Agencies concerned with alcohol abuse have been joined in their opposition by health and community groups. Minister of Health Michael Bassett is worried, and Minister of Broadcasting Jonathan Hunt has called for a delay until new broadcasting legislation is introduced later this year.

Among members of parliament annoyed at the decision — both government and opposition — one said he would, if necessary, introduce a private member's bill to overturn the decision.

The BCNZ's move to free up its rules followed the lead of private radio stations and came soon after two government-appointed inquiries — one on liquor laws and the other on violence — called for more research into the effects of liquor advertising.

A poll of public attitudes to liquor shows 59% would like liquor advertising banned on TV and radio.

Major liquor interests say they did not ask for the right to advertise their products on TV or radio and that they will not do so unless a competitor goes to air.

Douglas Myers, managing director of Lion Corporation, the country's biggest brewery: "It's a dumb way of going about it. They are just doing it to make money. We did not ask for it, but if we use it, we will be blamed by a community that is as yet unconvinced about its innocence."

He admits his company is a potential broadcasting advertiser, but an "apprehensive" one.

"I do not think we will initiate any advertising. But, we would respond if any competitor was out there beating us to death on television."

Existing broadcasting rules are that the names of manufacturers and sellers of liquor may be advertised, but not brands, prices, or specific qualities of products. So, Lion Corporation may be advertised, but not Lion beer.

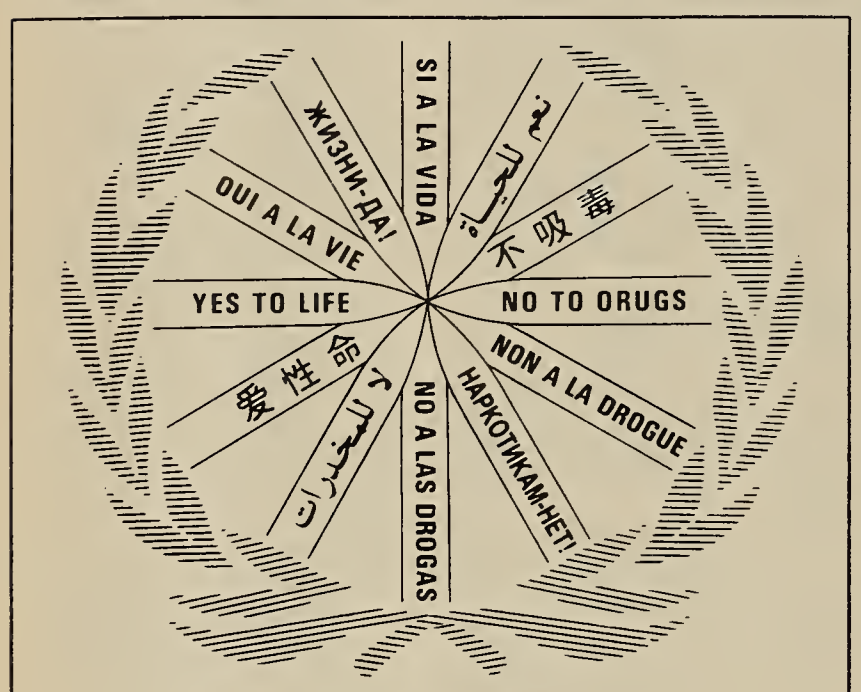
Ironically, breweries are prevented from drawing attention to their low-alcohol beers.

While the broadcasting corporation has yet to announce its new rules for state TV and radio, private radio stations have agreed to follow the code of advertising practice that applies to print media.

Among provisions are that liquor advertising should not encourage underage drinking, suggest a relationship between liquor and sex or romantic situations, show people consuming before work or driving, or suggest that alcohol is necessary for success, pleasure, or excitement.

The private broadcasters also recommend rules limiting the frequency of liquor advertising.

As opposition to the BCNZ decision mounts, its chairman, Hugh Rennie, said it might take six months for new rules to be adopted, after consultation with interested parties.



UN conference logo

VIENNA — Yes to life, no to drugs is the motto of the International Conference for Drug Abuse and Illicit Trafficking (ICDAIT) to be held here in June. The logo (above) forms a "petal" in the six United Nations languages.

Up to 15% NZ physicians addicted

Hotline for doctors

AUCKLAND — A confidential hotline service for doctors with alcohol and other drug problems is being set up nationally, at the instigation of the Medical Council of New Zealand.

Chairman Stewart Alexander said the council proposed the service — which will operate independently — because of concern about the number of doctors addicted to alcohol and other drugs as a result of professional pressure.

He believes significant and extensive addictions problems among doctors are not coming to light "because they are not quite bad enough."

Dr Alexander said indications are that as many as 15% of doctors developed some kind of addiction because of stress.

Calls to the hotline — whether from a doctor with problems, or from a concerned colleague — would bring together a squad of medical experts who could be summoned at short notice.

One of the doctors setting up the service, Malcolm Mowat, Canterbury University, recently wrote in the *New Zealand Medical Journal* that he knew of 26 doctors from one area who were approached about, or had treatment for, alcohol and/or other drug addiction.

In 10 years, seven died; only one died sober. Of those still alive, eight are currently sober and 11 are drinking (or drugging). Of the 11, none has attended Alcoholics Anonymous or Narcotics Anonymous on a regular basis.

Smokers resist

TEL AVIV — A draft bill banning smoking in all places of employment, closed sports facilities, waiting rooms, trains, and inland air flights — except in specific smoking areas — has created a boomerang effect here.

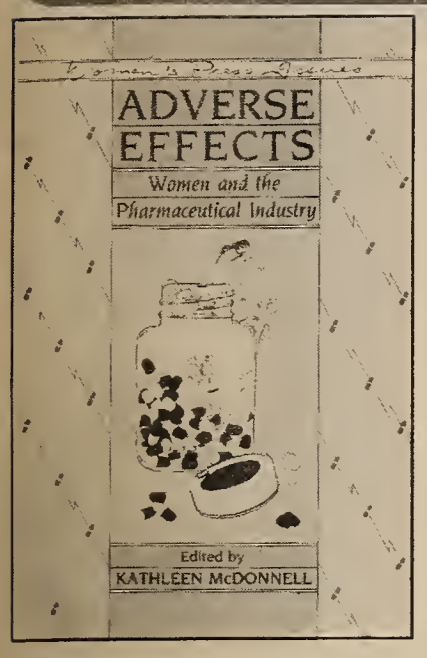
A much less specific law, passed in 1984, banned smoking in closed amusement areas, buses, taxis, and medical facilities.

But, the new draft bill seems to be meeting with more resistance. There have been enough articles in the local press, quoting resistance movements abroad, that the Israeli Ministry of Health publicly stated the proposed law's intention was not to outlaw smoking, but to protect non-smokers from the poisonous effects of inhaling someone else's tobacco smoke.

REVIEWS

New Books

by Margy Chan*



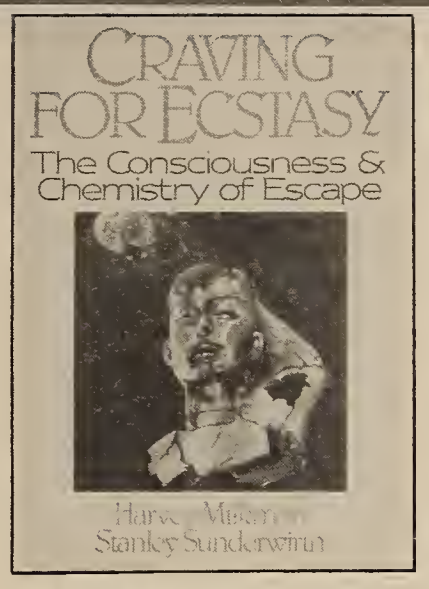
Written by a team of women health activists, the book examines, through a series of case studies in industrialized as well as Third World countries, the dangers women face from a powerful, global drug industry.

Women are easy targets for the pharmaceutical industry and population control policy makers because of special health needs and traditional roles as health providers.

The "pill-for-every-ill" mentality has brought the drug industry enormous profits; the book examines some efforts to challenge the power of the multinational pharmaceutical companies.

What is needed is a new approach to health which combines the rational use of modern drugs with respect for traditional remedies and health systems.

The Women's Educational Press, Toronto, Canada. 1986. 217 p. ISBN 0-88961-108-4.



This book is about ways people lose control of their lives through striving for pleasure and escape. The authors, well-known researchers in the addictions field, cover a wide range of compulsive behaviors: the use of mind-altering substances and activities such as work, sex, eating, watching television, sky-diving, gambling, etc.

Throughout the book, the biochemical, psychological, and social similarities underlying compulsive needs and excessive behaviors are uncovered.

The book concludes with "a consumer's guide to good and appropriate treatment." A Counselling Interest Inventory is also included so readers can identify the psychotherapy systems most likely to be compatible with their philosophies and beliefs.

Written for the non-professional the book avoids technical jargon while communicating the most advanced theoretical, research, and treatment perspectives. It is a very readable book for anyone interested in human addictions.

Lexington Books, Lexington, Massachusetts. 1987. 222 p. $25; paperback, $12.95. ISBN 0-669-12337-4.

Drunk Driving in America: Strategies and Approaches to Treatment

. . . Stephen K. Valle, editor

This collection of articles relates to research, policy, and treatment approaches to drunk driving. The authors represent a wide range of training and experience, including academic, research, correctional, public health, and judicial system backgrounds.

A comprehensive review of the problem of alcohol and traffic safety in the United States is included. A number of creative approaches to treating the drunk driver are presented. Special populations in driving-while-impaired programs are highlighted. The book concludes with a description of a new, bold treatment approach to the incarcerated multiple offender.

The monograph is also published as the *Alcoholism Treatment Quarterly*, Vol 3, no 2, 1983.

The Haworth Press, New York, NY. 1986. 176 p. $22.95. ISBN 0-86656-603-1.

The EAP Solution: Current Trends and Future Issues

. . . Jerry Spicer, editor

Employee assistance programs (EAPs) have grown rapidly in the last few years. There has been tremendous diversification in the EAP field as new service models expand on the original occupational alcoholism programs.

The book provides an overview of a complex field, encompassing many of the current EAP models. It discusses the basic services of EAP programs: counselling, communications, management consultation, marketing, evaluation, cost-benefit analysis, and research. Bibliographic references are included at the end of most chapters. It concludes with an analysis of future trends and current issues.

Hazelden Foundation, Center City, Minnesota, MN. 219 p. ISBN 0-89486-405-X.

Co-starring Famous Women and Alcohol

. . . by Lucy Barry Robe

This book is more than just collective biographies of famous women and their alcohol use; it illustrates how fame and stardom get in the way of recovery. The book also explores roles of family, loved ones, and medical professionals. It shows how stars recover and deal with issues of public recovery and AA (Alcoholics Anonymous) anonymity. It is readable, with an extensive bibliography and an alphabetical list of famous women with alcohol problems.

CompCare Publications, Minneapolis, Minnesota, MN. 537 p. ISBN 0-89638-100-5.

Books Received

Diagnosing and Treating Co-dependence: A Guide for Professionals Who Work with Chemical Dependents, Their Spouses and Children — Timmen L. Cermak. Johnson Institute Books, Professional Series, Minneapolis, MN, 1986. 112 p. ISBN 0-935908-32-3.

The Mentally Disordered Offender — Seymour L. Halleck. US Dept of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, Rockville, MD 20857, 1986, 215 p. DHS Publication No 86-1471.

Different Like Me: A Book for Teens Who Worry About Their Parents Use of Alcohol/Drugs — Evelyn Leite and Pamela Espeland. Johnson Institute Books, Minneapolis, MN, 1987. 110 p. ISBN 0-935908-34-X.

** Margy Chan is manager of the Addiction Research Foundation's library, the leading library in the field worldwide. A graduate of the University of Hong Kong, she holds a master's in library science from the University of Toronto.*

ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

The Battle Against Heroin

Number: 770.
Subject heading: Heroin: treatment/rehabilitation.
Time: 30 min.
Synopsis: Heroin use among young people is a problem across Britain. Parents in small communities think the police are not doing enough to protect their children. One family tells what they did to combat their daughters' heroin use. First, they kept them in the house for two months; however, as soon as the girls were allowed out, they resumed use. There are not enough treatment facilities in Britain, and the National Health Service does not allocate money for heroin treatment. The two girls finally enter treatment, and there appears to be hope for them.
General evaluation: Fair to good (3.8). The film is well-produced but is lengthy. As the statistics only relate to Britain, use in North America is limited. The story of the two girls is well done and has great emotional impact.
Recommended use: With a resource person, the film could be used with health professionals.

Not My Kid

Number: 775.
Subject heading: Youth and drugs; treatment/rehabilitation.
Time: 90 min.
Synopsis: This is the story of how one family responds to a child using drugs. At first, Susan denies her use, but her father continues to press her. A younger sister tries to stop her, and Susan physically abuses her. Susan's parents learn she has been skipping school and failing her courses. When her father follows Susan to school, she runs away. Two days later, she is found with drug-using friends. After an unsuccessful psychiatric session, Susan is taken to a treatment centre. The head of the centre tells her parents only kids with similar experiences can help Susan now. In group and family sessions, Susan is resentful, angry, and uncooperative. She runs away, but her father takes her back to the centre. Slowly, the family members begin to work on their problems. Finally, Susan is allowed to go home for family visits.
General evaluation: Fair (3.4). This made-for-television film is well-made and has emotional impact. One limitation is that the treatment modality shown is not the only way to deal with drug-using youth. The film is too long for general education use.
Recommended use: With a resource person, the film could be used with parents.

The Cat Who Drank Too Much

Number: 781.
Subject heading: Alcohol and alcoholism: overview.
Details: 12 min, video only.
Synopsis: Julie Harris narrates the story of Pat, the cat who had a wonderful life but did not feel that it was wonderful enough. Pat tries drinking, but things get much worse: Pat's family suffers, Pat is haunted by fears, and has a nightmare about riding in a car and having a bad accident. Finally, Pat can stand it no longer and seeks help. Things are much better.
General evaluation: Good to very good (4.9). Light-heartedly, the video covers issues related to drinking in a way that could stimulate discussion with many groups.
Recommended use: The video would benefit all audiences, especially patients in treatment.

Cocaine Country

Number: 780.
Subject heading: Cocaine.
Details: 32 min, video only.
Synopsis: The video opens with a statement that cocaine use is rampant in the United States. Tom Brokow interviews users, businessmen who report heavy use in the work force, residents of a treatment centre (Phoenix House), and the US commissioners of baseball and football. Finally, US first lady Nancy Reagan encourages everyone to be involved in preventive education and to stand up and "say no" to drugs.
General evaluation: Fair (3.3). This video was meant to be shown on television and, without commercials, appears to be disjointed.
Recommended use: General audiences.

Career Opportunities . . . Career Oppor

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

1st Pacific Institute on Addictions — May 5-8, Langley, British Columbia. Information: Karl Burden, Alcohol and Drug Concerns Inc, 11 Progress Ave, Ste 200, Scarborough, Ontario M1P 4S7.

Emergency Room Aspects of Crack and Cocaine — May 6, Toronto, Ontario. Information: Lorne Greenspan, emergency dept, Toronto General Hospital, 101 College St, Toronto, ON M5G 1L7.

Medical Aspects of Crack and Cocaine Abuse — May 6, Hamilton, Ontario. Information: F.G.H. Baillie, director, emergency services, Chedoke-McMaster Hospital, Chedoke Hospital Division, Box 2000, Stn A, Hamilton, ON L8N 3Z5

Prevention Congress III, Working Together to Build Healthy and Supportive Communities — May 6-8, Kitchener/Waterloo, Ontario. Information: Prevention Congress III, Lutherwood, RR 3, Waterloo, ON N2J 3Z4.

29th Annual Assembly of the College of Family Physicians of Canada — May 10-13, Halifax, Nova Scotia. Information: College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario M2K 2R9.

PRIDE Canada 3rd National Conference on Youth and Drugs — May 14-16, Saskatoon, Saskatchewan. Information: Eloise Opheim, president, PRIDE Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Drug Abuse in the Workplace: Drawing the Line — May 27-28, Toronto, Ontario. Information: Maureen Huntley, Corpus Information Services, 1450 Don Mills Rd, Don Mills, ON M3B 2X7.

1st National Conference on the Health Effects of Indoor Air Quality — May 29, Montreal, Quebec. Information: A. Les McDonald, director, Health Education and Program Services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7, or M. Gosselin, 7131 de Lorimier Ave, Montreal, PQ H2E 2N7.

87th Annual Conference of the Canadian Lung Association — May 29-31, Montreal, Quebec. Information: Les McDonald, director, Health Education and Program Services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

Duty to Treat *vs* Right to Consent: Striking the Balance — June 2, Toronto, Ontario. Information: Nancy Forbes, educational services dept, Queen Street Mental Health Centre, 1001 Queen St W, Toronto, ON M6J 1H4.

Work and Well-being 87 — June 12-14, Edmonton, Alberta. Information: Canadian Mental Health Association, #200, 12120 - 106 Ave, Edmonton, AB T5N 0Z2.

Canada Safety Council 19th Annual Conference — June 14-17, Toronto, Ontario. Information: Marie Juneau, director, national services, Canada Safety Council, 1765 St Laurent Blvd, Ottawa, ON K1G 3V4.

Summer School for Addiction Studies — July 6-24, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1

28th Annual Institute on Addiction Studies — July 12-17, Hamilton, Ontario. Information: Betty Collins, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

United States

20th Anniversary Haight-Ashbury Free Medical Clinics Drug Abuse Conference: Chemical Dependency Treatment and the Clinically Challenging Client — May 2-3, San Francisco, California. Information: Mim Landry, Haight-Ashbury Education Group, 409 Clayton St, San Francisco, CA 94117.

Northeastern Conference on Alcohol and Drug Dependence — May 3-6, Newport, Rhode Island. Information: Jane A. Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Road, Newport, RI 02840.

National Conference on Alcohol, Drugs and Women — May 3-6, Denver, Colorado. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St, Ste 181, Washington, DC 20001.

8th Annual Conference on Substance Abuse: Making a Difference — May 27-29, Cincinnati, Ohio. Information: Theresa Miller, program director, Central Community Health Board of Hamilton County, 520-532 Maxwell Ave, Cincinnati, OH 45219.

12th International Summer School on Chemical Dependency and the Family — June 1-4, Moorhead, Minnesota. Information: Debby Thornton, dept of social work, Moorhead State University, Moorhead, MN 56560

Children at Risk: Alcohol and the Elementary Student — June 18-20, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

30th Annual Institute of Alcohol and Drug Studies — July 26-31, Austin, Texas. Information: Bill Britcher, Texas Commission on Alcohol and Drug Abuse, 1704 Guadalupe, TX 78701-1214.

American Hospital Association Annual Meeting — Aug 3-5, Philadelphia, Pennsylvania. Information: John A. McMahon, president, 840 N Lake Shore Dr, Chicago, Illinois.

Abroad

3rd Annual International Industrial Alcoholism Symposium — May 25-27, Frankfurt, West Germany. Information: Sara Bilik, symposium chairperson, Conecta Partners, Berger Strasse 211, 6000 Frankfurt 60 FRG, West Germany.

16th International Institute on the Prevention and Treatment of Drug Dependence and the 33rd International Institute on the Prevention and Treatment of Alcoholism — May 31-June 5, Lausanne, Switzerland. Information: International Council on Alcohol and Addictions, Case postale 189, 1001 Lausanne, Switzerland.

Alcoholism and Drug Abuse, International Symposium — June 27-29, 1987, Rio De Janeiro, Brazil. Information: Continuing Education Abroad, 38760 Northwoods Dr, Wadsworth, Illinois 60083.

International Conference on Drug Policy Reform — July 13-17, London, England. Information: Drs Beyerstein and Alexander, dept of psychology, Simon Fraser University, Burnaby, British Columbia V5A 1S6, or Robert Fitton, conference coordinator, School of Justice, American University, Washington, DC 20016.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Secretariat, 6th World Conference on Smoking and Health, c/o Japan Convention Services Inc, Nippon Press Centre Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.

Teachers need help with drug lessons

'Give us information to work with,' they say

By Terri Etherington

GANANOQUE, Ontario — Teachers don't have to be magicians to identify students who are abusing alcohol or other drugs. They can simply spot the kids with problems as they walk through school corridors.

But, knowing what to do for the kids, knowing how to reach them with educational programs, knowing where to send them for counselling or treatment, knowing how to keep other students from joining their ranks, and knowing that whatever teachers themselves do, school administrations, school boards, and the courts will back them up — are vital concerns that still need to be addressed.

At a two-day conference on Alcohol and Drug Prevention for the School Community, sponsored by the Addiction Research Foundation (ARF), Toronto, teachers from eastern Ontario expressed frustration — frustration caused by lack of support from government, school boards, principals, parents, and even the media.

Despite these frustrations, these same teachers are pushing ahead with assemblies, with lesson plans, and with information evenings to try to reach their students with the drug education message. Programs and possibilities are as wide ranging as the number of schools involved and as imaginative, or as skeletal, as the individual schools deem necessary.

Nick Warus, head of guidance at Listowel District High School, Listowel, Ontario, and a consultant to the Perth County Board of Education, told **The Journal** the ideal program is one which helps young people formulate values and "gets kids talking with kids on topics related to alcohol and drugs."

What teachers need, he said, is content to help initiate the process.

In his school, the answer was a two-week program, essentially turning the school into a conference hall, with information on alcohol and other drugs in all classes, signs, posters, and information tables throughout the school, and evening sessions for the parents.

Noble gestures

Mr Warus believes that too often alcohol and other drugs are dealt with in physical education classes, in three or four lessons. "A noble gesture," he calls it, "which falls far short of having impact."

Or, it is dealt with in a special assembly. "The students walk in, look for a girlfriend, hold hands, rub cheeks, and sit down. It sure beats sitting in a classroom, and they don't really care what you are doing up there. They are not going to be critical."

What's needed, he said, is to involve students in dialogue, to get them to think and rethink, and to express their attitudes and feelings to each other as peers. And, "if they take some of the stuff home and bounce it off the family, I'm happy."

Getting parents involved is one of the keys to success, Mr Warus adds. "The parents are concerned, but they look to the school to do it, and, damn it, we can't do it alone. We have to do it with them. For us to try to do it alone is shovelling sawdust against the wind.

"I got a call last week on AIDS. They want us to do an assembly. I've also got the heart people and the lung people . . . every cause is a worthwhile cause, but we can't do a two-week program on every one of these things."

Other teachers at the conference echoed his concerns. Throughout the meeting, the question of AIDS education kept popping up.

One teacher suggested the provincial Ministry of Education be asked to prioritize the health-related items needing to be addressed.

"You tell us which is the most important. You tell us how much time we should be spending on it. And then, give us some information, some curriculum guidelines to work with."

Carl Ward, a teacher at North Dundas District High School, Chesterville, Ontario, said the lack of focus from the four ministries (education, health, social services, and corrections) "that should have their eyes open to the situation" is frustrating.

"Until those four ministries sit down and take a serious look at the problem, all we can do is make little dents in the whole issue."

Responsibility, guilt

Teachers do sometimes feel responsibility, or guilt, when a student is killed in a drinking and driving accident or develops serious problems with drug abuse. But, Mr Ward says, "the degree of responsibility is measured against all the other things that you're asked to be responsible for.

"If you've got to be responsible for AIDS and for every other thing, the degree of responsibility you can give to this is limited to the amount of time you have."

Mr Warus, on the other hand, says: "Alcohol and drug use is a major concern with teachers, because whether we are teaching English or math, we know this is window dressing, ultimately, in terms of what this kid's doing with his life. And, we'd like to feel that what we are doing is in some way supportive or relevant to preparing him for future happiness or survival outside the classroom."

The key, suggests Mr Ward, who developed the student alcohol and drug policy for the Stormont, Dundas, and Glengarry Board of Education, is recognizing that most behavior is motivated by a desire for recognition.

If students are getting the recognition they seek by using alcohol and other drugs, by belonging to peer groups which use drugs, then a way must be found to replace that recognition with some other form of recognition.

Young people need something in the curriculum to help them learn to socialize; many people never have the opportunity to interact socially without alcohol.

In any case, Mr Warus says, teaching temperance to young people is apt to fail. Young people drink to get drunk (**The Journal**, December, 1985). "This is an accepted value by kids."

Mr Ward: "When you get back to school on Monday morning and you didn't play hockey on the weekend, or didn't do something else considered important by your peers, you can always talk about how bombed you were Saturday night."

It is the ride home which concerns Don Derraugh, a geography teacher at Arnprior District High School, Arnprior, Ontario.

He's also been teaching driver education at the school since 1967, and that's where his interest in alcohol and other drug programing began. In fact, until recently, information on drinking and driving through driver ed programs was one of the few ways the issue was handled at his school.

But, Mr Derraugh says, there are frustrations.

For Grade 11 students at the school, there is one drinking and driving assembly a year, at which a film is shown and the police and a victim of a drinking and driving accident tell their stories. Two years in a row, students in the Grade 11 class were picked up for drinking/driving offences on the same night as the assembly.

The Arnprior school now has a policy on alcohol and other drugs, outlined to Grade 9 students each year by Mr Derraugh and the school vice-principal. But, Mr Derraugh is frustrated by the lack of judicial backing on both the drugs policy and on drinking and driving.

A militant sound

"We can only take policy so far. The school board can't lay a charge, it has to be the police officer, and sometimes even the police officers are reluctant to push it. The youth gets off, or the sentence is two years' probation."

Sandra Philip has been teaching lessons on alcohol and other drugs to her Grade 7 students at Hillcrest Public School, Campbellford, Ontario, for many years.

"I don't want to sound militant, but I think (alcohol and other drug education) should be almost enforced." More attention should be paid in professional development sessions, and the Ministry should "lay down some very strict guidelines such as they are doing with all subject areas.

"They say we must teach fractions in Grade 7, and we do that."

Ms Philip has been taking Grade 9 programs on alcohol and other drugs from other schools and watering them down to suit her younger students; she doesn't think that is enough. Teachers, she says, should get together to develop programs that work.

"We are educating kids about reading and writing and all the basics. This is basic, this is life. And, we have to start worrying more about life skills because of the complexities in our societies and the pressures on these kids today."

Ms Philip says there is also a need for ready resources to deal with children having problems. She'd like a resource person in each school and ways to treat or help the children now, not in two weeks. "I feel when you are dealing with kids, you sometimes have to put aside all this paper work, red tape, and legal jargon, and deal with them at the grassroots level."

Dealing at that level carries its own problems, say two private school nurses. The situations are different for Pat Cooper, a nurse at Trinity College School, Port Hope, Ontario, and Shirley Eby, a nurse at Lakefield College, Lakefield, Ontario.

For many of the boarding school students, the nurses are as close as family, hearing of the aches and pains and dealing with the day-to-day malaise of the young people.

"As health professionals, we can't ignore the problems," said Ms Cooper. "And, it is getting worse every year, despite what the statistics show."

While they may see the problems associated with use, they believe everyone in the school should be involved and informed, including teachers, office staff, and even the housekeepers, who may find marijuana stashed under the bed.

Like teachers and guidance counsellors, they're concerned about confidentiality and the balance between enforcing the rules and helping students in trouble.

In some ways, they feel the system and the policy is unfair. As Ms Eby says, a company employee in trouble with alcohol or other drugs is given leave with pay. Students, however, are automatically expelled for drug possession.

Burn-out

In fact, many school systems are beginning to recognize that dealing with alcohol and other drugs in schools means dealing not only with the students, but also with staff.

Bernard Warner, superintendent of schools, Stormont, Dundas, and Glengarry Separate School Board, Cornwall, Ontario, outlined the board's employee assistance program, developed with assistance from the ARF.

Now into its fourth year of operation, the program offers an outside referral agency to help teachers and school staff deal with personal problems, including chemical abuse.

The benefits are many, Mr Warner said. Long-term disability claims have dropped substantially, and teacher burn-out has been diminished.

And, the benefits are filtering down to the students.

"It is getting to the students one way or another, even if it doesn't get to them in a direct way. It is bound to have an effect on students if the teachers are healthy and their self-esteem is up."

THE BACK PAGE

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The Journal

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INSIDE

Drug strategy set for global debut

Anne MacLennan reports

TORONTO — Just weeks before he unveils it at the first-ever, world meeting of government ministers on drug issues in Vienna this month, Health and Welfare Minister Jake Epp announced Canada's new national drug strategy here.

Action on Drug Abuse/*Contre les Drogues* is a $210 million, five-year plan to help reduce drug abuse.

The new and additional federal dollars will be distributed across six key areas: $81.9 million to treatment; $69.3 million to education and prevention; $39.9 million to enforcement and control; $10.5 million to information and research; $6.3 million to international cooperation; and, $2.1 million to national focus.

The announcement by Mr Epp, the lead minister on the strategy, was followed by pledges across the country of new initiatives by other, directly-involved ministers.

Following a briefing here of chiefs of the Canadian provincial addictions agencies and related agencies and organizations, and a press conference, Mr Epp sketched his hopes in an exclusive interview with **The Journal**.

Five years from now, he said, "I hope we see a greater awareness of the tragedy of drug abuse and its costs. By costs, I'm not looking at financial costs primarily, but at human costs — to families, communities, schools."

There is awareness now, he said, but, "too few people know where to go for information, help, and support."

As for "evidence of success, if we see fewer and fewer young Canadians in our rehabilitation centres, in our hospitals, that will be the evidence that will satisfy me."

Chiefs of provincial addictions commissions across the country greeted the announcement with enthusiasm tempered by the knowledge that the launch is only the beginning and, in implementation, there will be frictions and factions.

Mr Epp allowed there will be is sues of territoriality — province to province, government to govern-

(See New, p2)

ACTION ON DRUG ABUSE CONTRE LES DROGUES

Partners of IV drug users

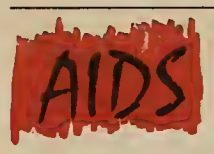
Women with AIDS: the file builds

By Paul Szabo

DENVER — AIDS is now the leading cause of death among women aged 25 to 29 years in New York city. And, of all new cases of the disease diagnosed in the United States last year, one-fifth were women.

It is facts such as these that largely detail the growing heterosexual transmission of the AIDS virus to women from partners who are intravenous (IV) drug users or bisexuals.

Some plain speaking on the issue took place at the 1st US National Conference on Women's Issues here, sponsored by the Alcohol and Drug Problems Association of North America, Washington, DC.



More on page 5

"Within the next couple of years, it's predicted that AIDS will be the leading cause of death for all women of child-bearing age in New York, and the majority of those who die will be minority women," said Mari Nobles, coordinator, Women in Crisis Inc, Project Return Foundation, New York city.

Three states — New York, New Jersey, and Florida — account for more than 70% of all women AIDS patients, she added, and women now constitute 7% of the total US AIDS cases diagnosed to date.

Women are contracting the disease through heterosexual transmission as well as by being IV drug users themselves.

The New York State Division of Substance Abuse estimates there are 50,000 female IV drug users in New York city, all of whom are at risk of contracting the disease. But, of more concern to Ms Nobles is the "special vulnerability" of women with high-risk sex partners.

She said statistics show "men have not shown up as having developed AIDS as a result of heterosexual activity in any significant numbers, while women have most certainly done so."

It's been estimated there are 120,000 male, current or former IV drug abusers living with women in heterosexual relationships in New York city. While the majority of

(See Women, p5)

Military trains guns on alcohol misuse

By Elda Hauschildt

SAINT JOHN, New Brunswick — Addiction prevention and treatment programs within the Canadian Forces (CF) are changing the military's attitude toward drinking, but it's taking $16 million a year to do it.

That's the cost of treatment and prevention for the 120,000 military and civilian personnel — plus their families — that the Canadian military is responsible for, Major Jim Jamieson told a workshop here at the Atlantic Addictions Conference 87.

The $16 million annual price-tag covers a wide range of prevention activities — every CF member must attend one drug education session a year, and every CF supervisor must attend one half-day program at least once a year — plus the cost of caring for approximately 600 alcohol and other drug patients at six military clinics annually (**The Journal**, October, 1985).

The Canadian military is "committed to the idea that we need to change the environment, and we're trying to deglamorize alcohol," said Maj Jamieson.

The military has come a long way since the first alcohol and other drug prevention program was established in 1971.

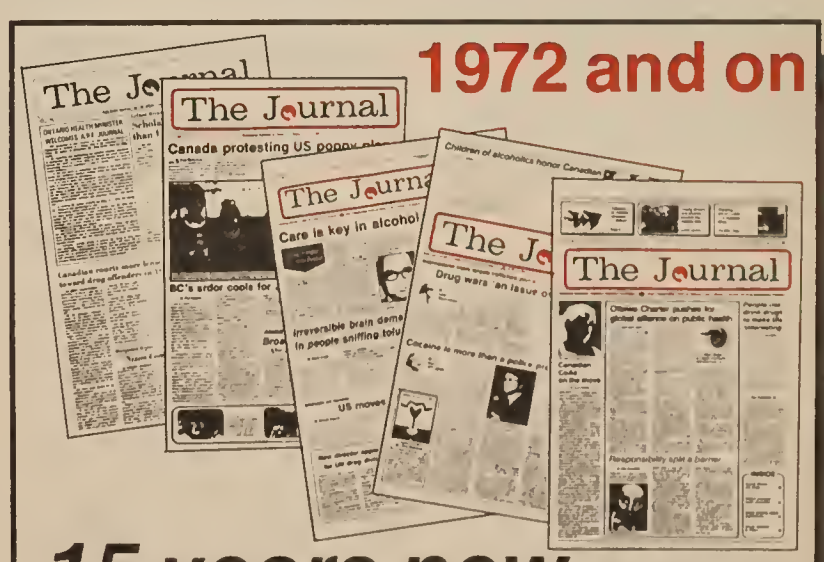
Maj Jamieson: "It used to be in the armed forces that if you didn't drink, you were a social outcast. I don't think that is true anymore; people who join the forces now can choose not to drink, can be quite open about that, and are not social outcasts.

"There may be a few, limited environments where there is still a lot of pressure, but at least we have changed some of those habits."

Other changes have affected CF drinking patterns, Maj Jamieson pointed out:

- "We do not allow subsidization of alcohol — no more happy hours or two drinks for one. Instead, we say, if you're going to give something away, give away food. Giving

(See Military, p2)



1972 and on 15 years new

TORONTO — The Report of Canada's LeDain Commission of Inquiry into the Non-Medical Use of Drugs dominated the first issue of **The Journal**, published by Ontario's Addiction Research Foundation, in June, 1972.

How long ago that seems, and how the field has changed. This month, 15 years of coverage of all aspects of the addictions field — research, treatment, prevention, and education — later, **The Journal** is reporting on the spread of AIDS among women (see story, above).

For all those 15 years, **The Journal** has been there for you, our reader — there to report on new drugs of concern, new specialties, new research, new techniques, changing trends — locally, nationally, and internationally.

We trust we've served you well; we'd like to serve you better. To help us help you, let us know what you think of what we have done and are doing; let us know your needs. Write: **The Journal**, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

NEWS

Briefly . . .

Light fingers

TORONTO — Shoplifting has gone up dramatically since the advent of self-serve liquor stores, especially in winter when people wear big coats with big pockets, says a spokesman for the Liquor Control Board of Ontario (LCBO), a report in *The Toronto Star*, indicates.

Crash of 87

NEW YORK — Officials say they have just touched the surface of widespread drug abuse on Wall Street after having charged 16 stockbrokers with selling cocaine and trading stocks for drugs. *Reuter* reports one undercover agent, posing as a stockbroker, found some brokers were spending $50,000 to $100,000 a year for cocaine. They were described as "fairly senior management" from major firms, who earned more than $1 million a year.

Born to AIDS

WASHINGTON — Most of the child victims of AIDS in the United States became infected before birth, and 86% of the 415 cases reported to the Centers for Disease Control, Atlanta, Georgia, have at least one intravenous (IV) drug-abusing parent. In the San Francisco area alone, between 25 and 40 babies will be born to AIDS-infected mothers this year, says *The Drug Abuse Report*. Increasingly, heterosexual transmission from previously infected partners will be linked to IV drug abuse, either on the part of the parents or the parents' other sexual partners.

No-go on ban

ALBANY — Sweeping regulations that would have restricted smoking in most of New York State's restaurants, public buildings, and workplaces have been struck down as unconstitutional by a judge, reports *Associated Press*. The regulations would have banned smoking in taxis, food markets, banks, auditoriums, and court houses, and limited smoking in other public areas.

Tiny bubbles . . .

LANSING, Michigan — Forget romantic visions of champagne with caviar or bubbly with other gourmet foods, says *Monday Morning Report*. A taste test of 56 foods found people liked their champagne better with cream cakes, chocolate cookies, or even frozen, breaded fish sticks than with traditional cuisine. The study, conducted by Palatex, Inc for Korbel Champagne, found tunafish sandwiches, hot dogs, and Chinese takeout to rate highly as well.

Brown-bag it

TORONTO — Senior citizens in North York (a city north of here) are having their medications inspected to weed out old, unnecessary, or potentially harmful drugs, in a campaign called The Brown Bag Program. *The Globe and Mail* says the program provides seniors with plastic bags to be filled with prescription and over-the-counter drugs which are inspected by the program's pharmacists.

Canada bans all tobacco advertising

Promotion is another target

OTTAWA — Calling cigarette smoking the leading, preventable cause of death in Canada, Health and Welfare Minister Jake Epp has announced comprehensive legislation here, banning all advertising and promotion of tobacco products.

The Tobacco Products Control Act, to take effect January 1, 1988, will replace the voluntary code on tobacco advertising adopted by the Canadian Tobacco Manufacturers Council in 1972.

Under the new provisions, all newspaper advertising of tobacco products will be banned starting January 1, 1988. Magazine advertising will cease January 1, 1989, at which time new restrictions on tobacco company sponsorship will go into effect, including a ban on the use of tobacco product trade marks or brand names.

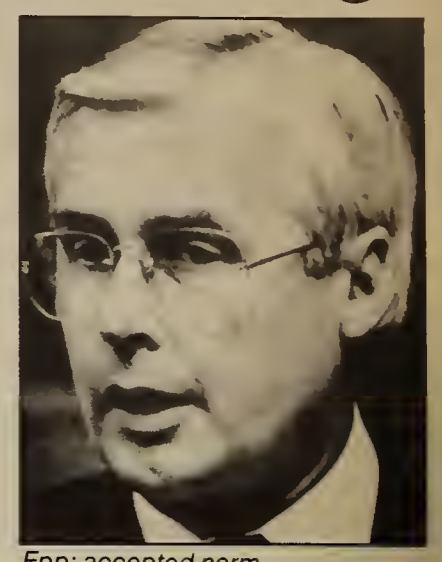
Other legislative provisions include:

- "strongly worded, prominent, and rotating health warnings" on packaging for tobacco products;
- toxic substances in tobacco listed prominently on packaging;
- requiring manufacturers and importers to report production, importation, and sales figures for their products; and,
- prohibition of promotional activities involving contests, coupons, or product sampling.

In addition to the Act, Mr Epp announced $2.4 million for new initiatives under the National Program to Reduce Tobacco Use.

"Eliminating tobacco advertising and promotion is an important step in moving toward a society in which non-smoking is the desired and accepted norm," said Mr Epp.

Penalties for contravention of the advertising sections of the Act would be up to a maximum of $1,000,000 and/or a six-month prison term for a first offence.



Epp: accepted norm

Manitoba ad rule used in tobacco protest

WINNIPEG — In Manitoba, Health Minister Jake Epp's proposed banning of tobacco ads was greeted with "guarded optimism" by Dr Richard Stanwick, a member of the province's Interagency Council on Smoking and Health.

"Our major concern is will these measures, in fact, see the light of day after the parliamentary process has its go at it?" he said.

Dr Stanwick said he believes the proposals are a step in the right direction; he's concerned some of Mr Epp's strongest opposition to banning tobacco ads may come from within his own political party.

Dr Stanwick, professor of social and preventive medicine, University of Manitoba here, is one of four Manitobans who presented a formal complaint about tobacco ads to the province's Consumer Affairs Minister Alvin Mackling.

Under legislation passed several years ago in Manitoba, any four people can complain and call for an official investigation into advertising they believe is harmful or misleading.

Dr Stanwick said the federal government's proposals won't mean the group will drop its efforts, just put them on the back burner for now.

"Who knows what will happen to the original law when it goes through Parliament? There may be loopholes we haven't recognized."

Cdn Forces

Recruits: drug alert

Military cuts back on alcohol

(from page 1)

away booze is virtually taboo now;

- "We do not allow people to be rewarded with booze;
- "At mess dinners and other functions . . . other alternatives have to be available and have to be attractively offered;
- "Our bartenders now have been given the authority, and training that they've never had, to cut people off. If they make the decision — no matter what the person's rank — that the person shouldn't be drinking, bartenders carry the base commander's authority;
- "When they're recruited, new personnel have to sign a statement that they've been told and understand that any use of drugs other than specifically prescribed by a physician could result in release from the forces."

Maj Jamieson said "one of the tragic things" about the previously high tolerance by the military of alcohol use by CF members is that "because so many people used to retire between the ages of 42 and 49 years . . . serious alcohol problems were spilling out into families.

"These were problems that were beginning to show themselves at work, but which we accepted at work because of the attitude, 'He's such a good worker when he's not drinking' type of thing.

"We know now from some tracing we've done that the serious health problems related to heavy use of alcohol did not show themselves until after the people got out of the Canadian Forces."

Canadian Forces to use survey to check prevention success

SAINT JOHN, New Brunswick —Canadian Forces will get a chance to see how successful their $16 million-a-year prevention and treatment programs have been when a 1982 Forces-wide survey of alcohol and drug use is repeated in 1988.

Major Jim Jamieson told an Atlantic Addictions Conference 87 workshop, the 1982 survey (The Journal, October, 1985) had shown:

- **25% of the military drank three or more drinks a day,**
- **11% drank five drinks or more a day,**
- **6% drank seven drinks or more a day,**
- **more than 20% of the young people in the military drank five or more drinks a day,**
- **more than 10% of the young people drank seven or more drinks a day,**
- **14% of the under-25-years age group were regular, ongoing cannabis users, and**
- **close to 40% used cannabis while in the military.**

He also said women in the Canadian Forces have a higher rate of alcohol use than their civilian counterparts.

"One of the cruel realities we are finding is that women in the Forces — who now comprise about 10% of our total person power — have an extremely high level of drinking."

New strategy calls for national drug conference

(From page 1)

ment, and provincial government to federal government.

Mr Epp: "At the level of officials in the addictions field, there has been nothing but cooperation, and we're not worrying about that.

"However, we have a federal state, and there are always ripples with respect to federal/provincial undertakings. But, I'm used to that.

"Obviously, there's going to be a lot of sensitivity needed here. A well developed, mutually satisfactory, federal/provincial partnership is of fundamental importance.

"And, I think it is absolutely critical that between now and next fall (1988), there are programs in place which would not have been in place if the strategy had not been announced." (The strategy also calls for a national conference on drug abuse late next year to see "where we've been, where we are, and where we're going.")

Mr Epp said the government began examining drug abuse issues 18 months ago, the strategy was drawn up, under Mr Epp, by an inter-departmental secretariat that began work in November, 1986.

H.David Archibald, founder and director for 25 years of the Addiction Research Foundation, Toronto, now president of the Switzerland-based International Council on Alcohol and Addictions, was a senior adviser to the strategy group.

He said the fact the strategy was developed by several, cooperating government departments, including health, justice, solicitor-general, youth, external affairs, itself puts Canada into a leadership role, ahead of the vast majority of countries.

"It reaffirms Canada's leadership internationally."

Canada, in the international forum, has always stressed the need for a balanced approach to drug problems -- not only addressing the supply of drugs but also the demand, or health, issues.

Next month:

The development of a national strategy

NEWS

No worry about FAS for light-drinking women

Wayne State study demonstrates risks rise dramatically after that

By Kay Jackson

LAS VEGAS — The light drinker who gets drunk about the time she becomes pregnant doesn't need to be concerned about putting her unborn child at risk of fetal alcohol syndrome (FAS).

In fact, if the mother drinks lightly and only occasionally the fetus will not be at risk of FAS at any time during the pregnancy, says a report from Wayne State University, Detroit, Michigan.

The study was reported here at the annual meeting of the American College of Obstetricians and Gynecologists. Its findings follow on the heels of earlier warnings about the consequences of any exposure of the fetus to alcohol during the first trimester (**The Journal**, July, 1986).

"We found women who drink a little around the time of conception have the same number of congenital anomalies in their babies as do abstainers," said Robert Sokol, MD, chairman of the department of obstetrics and gynecology, Wayne State.

"However, once a woman drinks more than four drinks a day, there is a major and significant increase in the number of congenital anomalies in the children."

Nevertheless, Dr Sokol said, women are still well advised to quit drinking "if they're thinking about getting pregnant."

"We get patients who are worried they may need to see a cytogeneticist because they were celebrating New Year's Eve or a promotion around the time they got pregnant. I think our data suggest we should be able to reassure these women that it is very unlikely they've damaged their baby and, therefore, they shouldn't worry throughout their pregnancy."

Heavy drinkers (more than four drinks a day) who have had a drunken episode around the time of conception "might require consultation and follow-up with a geneticist," Dr Sokol added.

This is because the amount of alcohol a heavy drinker would have to consume to become intoxicated is significantly more than a light drinker would need to become inebriated.

"We feel that while the infrequent, moderate drinker who gets drunk once around the time of conception may not be at risk, the heavy drinker whose tolerance to alcohol is much higher could expose her fetus to serious risk of genetic damage if she gets intoxicated at that time."

Analysis of alcohol and other drug habits of 8,300 women presenting to the prenatal clinic in Detroit also indicated that there is a critical period during pregnancy when fetal exposure to more than four alcoholic drinks a day is particularly likely to produce signs of FAS.

Pregnancy: heavy drinking out

This critical period extends from conception to eight weeks gestation, said Dr Sokol.

In the study, the babies born to 700 of the heaviest drinkers in the group were compared to a similar number of women who abstained or drank less than four drinks per day. Histories of alcohol and other drug habits were recorded.

The number of congenital anomalies seen in infants born to both groups were classified through a list of 31 congenital defects set out by the researchers. They included craniofacial defects such as small eyes, mal-positioned ears, and oral cavity abnormalities associated with FAS.

Results were adjusted for 12 other possible causes of congenital anomalies, including race and maternal age at delivery.

Agents turn college stars to drugs: NFL owner

By Harvey McConnell

CLEVELAND, Ohio — Some agents representing professional athletes are trapping them into drug use in college so the agents can have the right to represent the young people when they make it into professional sports.

"Hundreds of agents entrap seniors in college," claims Art Modell, owner of the Cleveland Browns of the United States National Football League (NFL).

"It is becoming a very big problem we have got to lick."

Mr Modell, speaking at the opening of the National Council on Alcoholism conference here, said 20 years ago, most players wanted to spend about five years in the pros and earn enough money and contacts to make it in the world outside.

Not now: "Today, players want to make all the money they can and retire by the age of 28."

The typical athlete has been chased and recruited since high school, has never worked a day, "he's given a scholarship and doesn't have to go to class, and then he comes to the pros," Mr Modell continued.

"There he's asked if he'll take a $500,000 signing bonus, or how about a $700,000 signing bonus or an annuity?

"And, this poor soul has yet to work a day in his life. Suddenly, there's all this affluence. He's ready to party; he started with marijuana in college, and now he graduates to the bigger stuff."

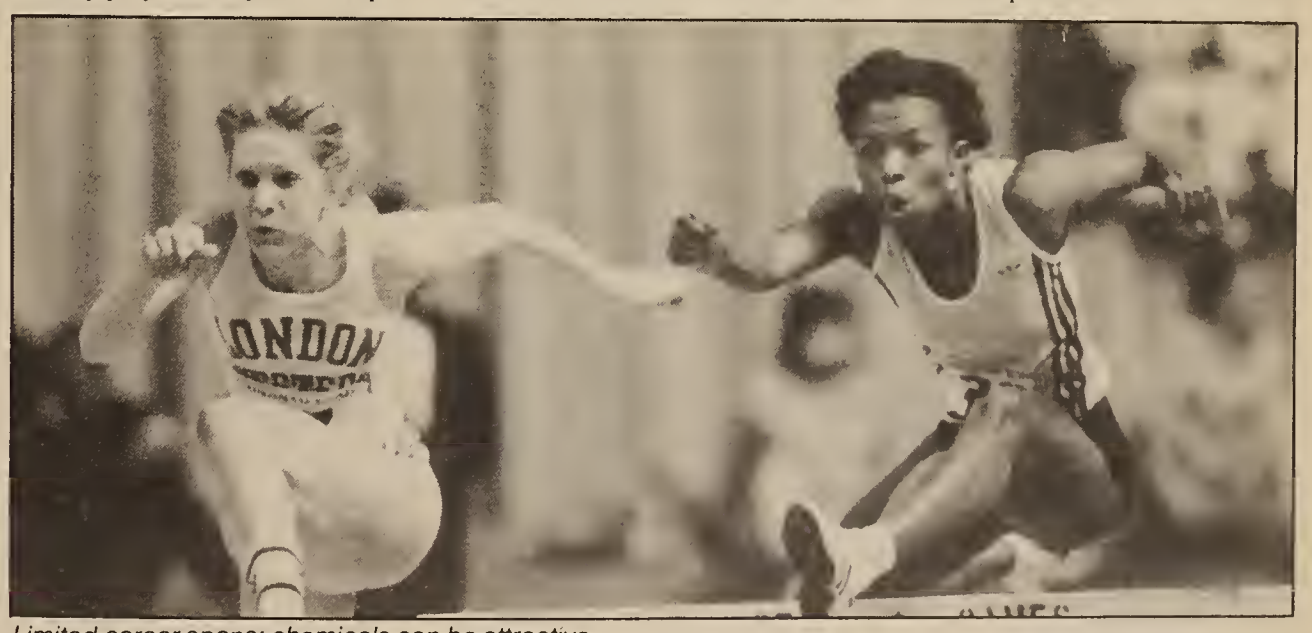
Mr Modell said the Browns have a drug rehabilitation program which has run for a number of years. However, it has had its ups and downs, says Gregory Collins, director of the alcohol and drug abuse program, Cleveland Clinic Foundation, and director of the Brown's program.

Dr Collins: "Despite our efforts, some of our players have continuous relapse. We made a lot of mistakes, but we've done a lot of good — we have some players with five years of uninterrupted sobriety."

Dr Collins said the subterfuges used by players early on in the program included substituting their girlfriends' urine at weekly examinations: unfortunately, many of the girlfriends were using cocaine; and, he had to tell two players they were pregnant.

The Browns were rocked last year by the death of team member Don Rogers from a cocaine overdose. (His death came eight days after the death of basketball star Len Bias [**The Journal**, February].)

Sam Rutigliano, former Browns coach, said he learned early on in the treatment program that when things seemed to be going well, that was the time to worry. Treatment program workers were devasted when they found so many players had been substituting urine samples.



Limited career spans: chemicals can be attractive

Kids who drink/drive — focus of new campaign

OTTAWA — The Canadian government has launched a 20-year campaign here to reduce impaired driving, aimed at young people aged 16 to 24 years.

"While young people represent only 16% of the population, they account for more than 36% of those apprehended for driving while impaired," said Health Minister Jake Epp.

"In addition, 70% of single-driver, weekend accidents involve young people, and about 50% to 60% of all traffic fatalities in this age bracket are alcohol related."

Approximately $20 million has been allocated for the first five years of the 20-year program.

Mr Epp pointed out changing social behavior takes time, "especially when the target group will have a large turnover in the first five years."

Canadian provincial and territorial governments, including Ontario's (see p2, Ontario Report), will participate in the program by helping to launch a promotional campaign, *Play it smart — when you drive, don't drink*, on radio and television.

Other key activities promised in the long-term campaign include:

- community-based activities involving "concerned citizens,"
- preventive driver education aimed at the new driver,
- server training for owners and employees of drinking establishments, and
- national advertising and promotion.

In announcing the new, long-term campaign, the government said it "recognizes the tremendous contribution" citizen groups such as Mothers Against Drunk Driving and People to Reduce Impaired Driving Everywhere have had in "changing the complacency that existed" over the impaired driving issue.

Separate pressure connected to drugs

Women athletes could be next

By Paul Szabo

DENVER — Women athletes and drug use will likely enter the public spotlight soon, an expert on the subject predicts.

The high degree of publicity being given to male athletes and use of illicit drugs leads Karla Hill-Donisch, a training specialist in the sports education program at the Hazelden Foundation, Minneapolis, Minnesota, to this conclusion.

"I'd like to believe women's sports are different from men's sports; I'm afraid they're beginning to follow the same patterns."

And, she told the 1st National Conference on Women's Issues here, women athletes face separate pressures that may lead them to be susceptible to forms of chemical dependency.

Female athletes, more often than males, have a limited career span and can be attracted to using chemicals to enhance their performance so they can keep up with younger competitors.

Ms Hill-Donisch also said many young women athletes are controlled to a high degree by their coaches and take performance-enhancing drugs at their request.

Because of their physical abilities, athletic performance is often the last thing that suffers when female athletes develop chemical dependence.

"They may be falling apart inside, but they may not show it on the field," she said.

However, there are many aspects about sports that can make it easier to educate young women about the dangers of chemical dependency. Coaches can become valuable teachers, and athletic ability can enhance self-esteem, the lack of which is often a key problem leading to addiction in this population.

Ms Hill-Donisch also presented results of one of the first surveys into drug use among elite female athletes, which showed a surprisingly high degree of drug use.

In the survey conducted at Hazelden last year, 273 elite female athletes ranging in age from 15 to more than 40 years responded to a five-page, mail-in questionnaire.

More than three-quarters of the athletes said they had used alcohol in the past 30 days while two-thirds said they drank both during competition and in the off-season.

Marijuana and caffeine were also identified as drugs frequently used by the athletes polled.

The poll also showed that 16 Olympic-level athletes are current tobacco users; one-fifth said they have used chewing tobacco.

As for more serious drug use and addiction problems in female athletes, she speculates that with female participation in sports becoming more publicized, illicit drug use among this group will also begin to get attention.

NEWS

RESEARCH UPDATE

Canadians plug into smokeless tobacco

Two Canadian studies show the growing popularity of smokeless tobacco with young people is not confined to the southern United States. A 1985 survey of 707 high school students in Fredericton, New Brunswick, by Loris Miller, RN, found 14.2% use chewing tobacco and 5.7% use snuff. A companion report, drawn on data from a November, 1982 survey in the Northwest Territories (NWT), found 17% of students use chewing tobacco. In both survey groups, the ratio of male users to female users is approximately four to one. In her survey, Ms Miller reports almost half of the students using chewing tobacco start before age 12 years. On the positive side, more than half of those polled said they disapprove of chewing tobacco and know it is harmful. The NWT survey shows sharp ethnic differences; Native children are far more likely to use smokeless tobacco than non-Natives. Use of chewing tobacco peaks in the 10-to-14 year age group and declines in the 15-to-19 year age group (students switch to tobacco, report two health officers). The NWT report by Jim Paterson and Luis Barreto, MD, made more extensive recommendations along similar lines.
Canadian Nurse, January, 1987, v.83:15-19.

Cocaine leaves its mark

The ability of intravenous cocaine use to cause extensive skin lesions has been documented by Californian researchers. Physicians Madalene Heng and George Haberfeld, dermatology division, University of California at Los Angeles San Fernando Valley Internal Medicine Program, Sepulveda, reported on the case of a 35-year-old white man who presented with necrotic plaques on his thighs, having injected a half grain of cocaine into his left arm vein four days earlier. Within four minutes of the injection, the man reported intense thigh pain and discoloration, followed by bruising and blistering of the area several hours later. He also developed a fever with chills, glomerulonephritis, and hepatitis. The researchers say the man reported a similar incident following an injection of cocaine a year previously; investigation by skin biopsy showed that the intravenous cocaine produced fibrin clots in the vessels of the skin resulting in focal areas of infarction. This thrombotic phenomenon, they say, was due to the drug and not any impurities contained in it. They also say the severe pain following injection could be attributed to the intense vasoconstrictive properties of the drug and the skin damage could be due either to prolonged vasoconstriction or the direct toxic effects of what was an overdose of cocaine.
Journal of the American Academy of Dermatology, February, 1987, v.16:462-468.

Doctors differ on liver diagnosis

The physical diagnosis of alcoholic liver disease should be viewed with caution, French researchers claim, following a study demonstrating poor agreement between physicians assessing damage to the liver. In the prospective study, six staff gastroenterologists at a French hospital looked for 18 clinical signs of alcoholic liver disease in 50 alcoholic patients. An independent examination had shown that 20 of these patients had alcoholic cirrhosis; 14 had non-cirrhotic, alcoholic liver disease; and, the remainder had no clinical or biochemical abnormalities. Statistical evaluation of the examination findings of the physicians showed good agreement on the presence or absence of some physical signs, but poor agreement on others. In addition, senior physicians showed significantly more agreement than did junior staff members. There was good agreement for signs such as splenomegaly and ascites, but poor agreement on hepatic consistency and white nails. The researchers say some of the poor agreement could be attributed to the high number of study patients with no abnormalities and the international lack of concurrent clinical and biological data which doctors would normally use to aid in their diagnosis.
Digestive Diseases and Sciences, March, 1987, v.32:244-247.

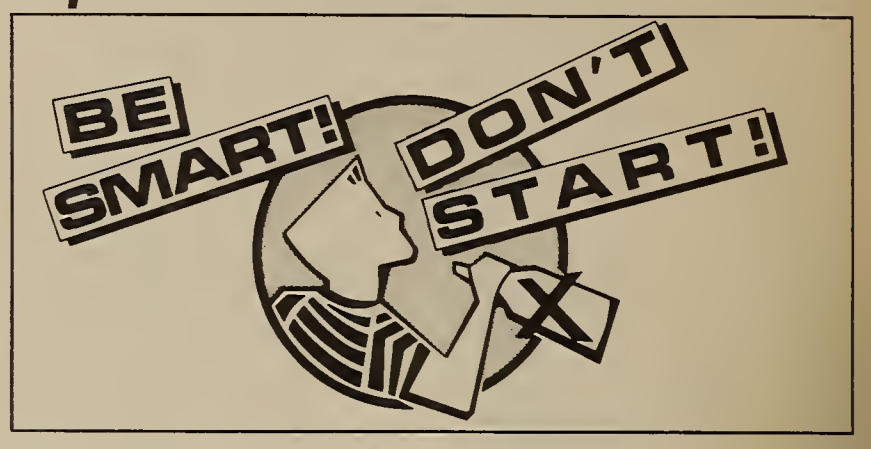
Ecstasy/Eve deaths

'Ecstasy' and 'Eve' can kill. A group of Texan researchers implicate methylenedioxymethamphetamine (MDMA) and methylenedioxyethamphetamine (MDEA), known as Ecstasy and Eve, in deaths of five people in a nine-month period in 1985/86. Their report is the first to appear in the medical literature linking recreational use of the drugs with fatal outcomes. The three researchers from the department of pathology, University of Texas Health Science Center, and the Southwestern Institute of Forensic Sciences, Dallas, said the five patients were examined by the chief medical examiner's office in Dallas County. In only one of the deaths, that of an 18-year-old woman who collapsed and died shortly after ingesting one-and-a-half hits of MDMA and an unknown amount of alcohol, was MDMA thought to be the immediate cause of death. In three of the other cases, MDMA or MDEA was thought to have contributed to death by inducing cardiac arrhythmias in people with pre-existing diseases. One of these patients was an asthmatic; the others had underlying heart disease. In the fifth case, a 22-year-old man electrocuted himself on a utility tower after taking an unknown quantity of MDMA. The report concludes that while the case reports do not resolve the controversy about the therapeutic benefits of MDMA in psychotherapy as opposed to the drugs' potential for abuse (**The Journal**, July, 1986), the cases show clearly that deaths related to these drugs do occur and that pre-existing heart disease may predispose individuals to sudden death while using these drugs. *Journal of the American Medical Association*, March 27, 1987, v.257:1615-1617.

Pat Rich

Early alcohol use main focus of new US prevention drive

By Harvey McConnell



WASHINGTON — A music video featuring the popular teenage group, The Jets, is the spearhead of United States President Ronald Reagan's latest prevention campaign on alcohol use by young people.

"If we are going to create a drug-free generation of youth, we must start by preventing alcohol use, and we must start with young kids," said Ian Macdonald, MD, director of the White House Office for Drug Abuse Policy and administrator of the Alcohol, Drug Abuse and Mental Health Administration, in launching the program at a press conference here attended by The Jets and several hundred young people.

The music video, television and radio public service announcements, and print materials are all aimed at the eight to 12-year-old age group with the slogan, Be Smart! Don't Start! Just Say No!

Dr Macdonald pointed out that the average age of first use of alcohol in the US is 12.3 years and alcohol is the most readily available and most frequently used drug among young people.

"Alcohol use is a watershed — when crossed, a child is far more likely to become involved in problem behaviors, such as other drug use, school truancy, and petty crime.

"Our society believes that relief is just a swallow away. It's time we taught kids to refuse the chemical way out."

Enoch Gordis, MD, director of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA), said: "While we have made great strides in the last few years to raise awareness about the harmfulness of using marijuana, we are finding that fewer high school seniors see the great risk associated with getting intoxicated at least once or twice each weekend.

"The percent who perceive this risk has dropped to 39% in 1986 from 43% in 1985. In addition, 45% of these seniors think that their friends approve of this behavior.

"It is too soon to know if those who have become aware of the dangers of marijuana are now thinking that heavy drinking is more attractive or not, but I think we should take this data as a warning."

Dr Gordis said that when the data started to indicate that the largest increase in youthful drinking takes place between the sixth and seventh grades and peer pressure begins in the fourth grade, "we realized that prevention that begins in seventh grade may be too late for lots of children" (see below).

The new campaign is being financed by NIAAA and the new Office for Substance Abuse Prevention, aided by contributions from state and local governments, and voluntary groups.

Peer pressure on pot eases up

WASHINGTON — Peer pressure among United States Grade 4 school children to try marijuana is dropping.

A survey by *Weekly Reader* — a classroom newspaper — of 500,000 fourth graders finds those reporting "some" or "a lot" of pressure to try marijuana has dropped to 25% in 1987 from 31% in 1983.

At the same time, the number of fourth graders who report school is where they learn the most about the dangers of drugs has risen to 32% this year from 15% in 1983. Those who believe cigarettes are a drug increased to 37% from 20% in the same period, and those who think beer, wine, or liquor are drugs rose to 50% from 42%.

There is still pressure on the kids, the survey finds: 24% report pressure from their peers to try cocaine or crack, and 34% to try wine coolers.

The *Weekly Reader* is published by Field Publications and distributed to six million children in grades 2 to 12. The survey was based on answers from 500,000 students, from which a random sample of 100,000 was analyzed.

Kids: fourth-grade coercion

US per capita alcohol use drops

Price/consumption link reinforced

WASHINGTON — Alcohol consumption in the United States continues to drop, and evidence continues to mount regarding the price of alcohol and alcohol-related problems.

Even so, 18 million people older than 18 years have an alcohol-related problem and 10.6 million are alcoholic, says the sixth special report to the US Congress on alcohol and safety.

The report says US per capita consumption fell to 2.65 gallons of absolute alcohol per person older than 14 years in 1984 from 2.76 gallons in 1981. In the same period, the proportion of fatally injured drivers who were legally intoxicated dropped to 43% from 50%.

The report, released by Health and Human Service Secretary Otis Bowen, MD, said there is increasing evidence of a relationship between the price of alcoholic beverages and alcohol-related problems.

One of the latest studies indicates that raising the price of beer can reduce the number of young people who drink, their incidence of frequent and heavy drinking, and the number killed in road accidents.

Alcohol is involved in nearly 50% of all accidental deaths, suicides, and homicides, including deaths in motor vehicle accidents.

The report adds that the evidence for a genetic component to alcoholism continues to increase: alcohol consumption causes marked endocrine abnormalities in men and women; and, changes, in the brain's neuronal membranes may be implicated in alcohol tolerance, physical dependence, and symptoms of withdrawal.

Patients as 'victims of self-injurious behavior'

Moralistic approaches may spill into drug field

By Harvey McConnell

NEWPORT, Rhode Island — Attaching a moral tag of "self-injurious behavior" to AIDS, in the wake of a burgeoning epidemic, could seriously damage the United States chemical dependency field in the future.

David Lewis, MD, professor of medicine and community health at Brown University, Providence, Rhode Island, spelled this out as a major concern at the Northeastern Conference on Alcoholism and Drug Dependence here.

Dr Lewis said the field, in general, must also become more aligned to the care of adolescent abusers, it must stop promising more than it can deliver, and it must worry about AIDS.

AIDS is the biggest concern.

Dr Lewis: "In some ways, AIDS is already a national calamity, and it is going to get a lot worse." And, if one looks at historical swings between moral and medical in terms of addiction attitudes and policies, "we are clearly in a medical era."

But, the direction can change, and AIDS can change it because as AIDS becomes something of a national disaster, most of the patients may be considered victims of self-injurious behavior.

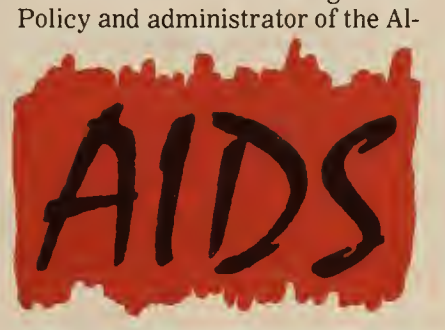
"This could change markedly some of the great advances we have made in treating people for the disease of alcoholism: this could be eroded in a significant way," said Dr Lewis.

"We might return to the moralistic view of drinking and drug use, and I am concerned about that."

Dr Lewis said many people now view AIDS among heterosexuals as a result of self-injurious behavior, and these people may start to look at other behaviors which could be construed as self injurious. He suggests that could swing the pendulum back toward considering alcohol and other drug use a moral issue.

As for the adolescent addict population, Dr Lewis said: "It is clear this (US) field is not paying enough attention to the adolescent population" or to moves toward more adolescent care.

US government signals are clear from Washington, and they're exemplified by the actions of Ian Macdonald, MD, director of the White House Office on Drug Abuse Policy and administrator of the Al-



cohol, Drug Abuse and Mental Health Administration.

And, the first action by the new US Office of Substance Abuse Prevention is announcement of a $24 million dollar program to fund prevention treatment and rehabilitation projects (see p4).

Dr Lewis said adolescent care "is an area of treatment that this field had better attend to, or else. I suspect that is tough — adolescent addiction care is not easy, but I think that is going to be an important area for the future."

He said the addictions field must "get on board and start to connect with early prevention and early intervention efforts."

Dr Lewis added that, in the past, the field has at times run into trouble because it has promised too much. Intense economic competition in the US among programs and strident marketing efforts have led many legislators and medical leaders to be turned off by promises they think cannot be fulfilled.

"We must not promise more from recovery from addictions than we can actually deliver."

Women at risk need specific information

(from page 1)

the women are not drug abusers themselves, Ms Nobles said, they are at risk and have to be educated about the dangers of AIDS.

". . . The media, which overall has done an excellent job covering AIDS issues, has been slow to pick up on gender-specific concerns for women," she said.

Articles tend to talk about the importance of safe sex and use of condoms, but "they do not explain in any depth the social difficulties women may encounter in trying to persuade their sex partners to use condoms and to adopt such practices."

These difficulties are especially prevalent in black and hispanic communities, and these are the very groups at highest risk of contracting the disease.

Ms Nobles explained that other barriers to warning women occur because, unlike homosexual men, women at risk may not have much else in common apart from being at risk.

This is not helped by prejudice lumping together sexually active women, prostitutes, and IV drug users as though all sexually active women are prostitutes and all prostitutes, IV drug users.

Irish campaign focuses on fidelity, drug users

By Karen Birchard

DUBLIN — Irish air and seaports now feature large posters, prominently displayed in departure lounges, warning travellers not to import AIDS.

The billboards are part of the government's long-delayed public information campaign, targeted at high-risk groups, which emphasizes prevention through fidelity to a single sexual partner.

The airport and ferryport posters simply say: "AIDS — Don't bring it home."

Ireland is spending more than 50 cents per person on the AIDS campaign, which does not recommend the use of condoms as an effective defence against the disease but says condoms provide some protection. Until recently, it was illegal to sell or buy condoms in Ireland because of the Catholic Church's stand against their use as a method of contraception.

It is impossible to buy condoms in some parts of the country; some pharmacists have refused to stock them on moral grounds.

The Irish public information campaign was delayed for six months for various reasons including a debate about whether to suggest the use of condoms. During that period, the Irish Bishops issued the statement: "The best vaccine is virtue."

However, the Church did set up a National Task Force on AIDS under the direction of Father Paul Lavelle, who has run a drug awareness program here for the past four years.

Father Lavelle has welcomed the government's approach because of its message of personal responsibility: "The question of condoms is secondary. The only sure way to avoid contracting the AIDS virus through sexual means is by maintaining 'one faithful partner' relationships."

Irish authorities have targeted drug abusers as a high-risk group, but they will not, as in some European countries, be given free needles (**The Journal**, May). Billboards aimed at drug users ask people not to shoot themselves with AIDS.

This city has a high proportion of pregnant drug users, some of whom have several children. Hospital care for pregnant women with AIDS antibodies is now standardized at the city's maternity hospitals. All patients with a history of hepatitis or drug abuse are routinely screened for antibodies, and special barrier nursing methods are used during delivery.

This city also has the second-highest number of infants found to be carrying the antibodies. Some of the babies are now producing negative tests and are being monitored fully to see whether they are in fact clear or whether it is a temporary condition.

AIDS is not a reportable disease in Ireland, but Minister for Health Rory O'Hanlon says a total of 19 cases had been confirmed and 11 of those people had died.

"We already know that despite extensive campaigns in other countries, many people do not see themselves as being at risk from AIDS in spite of their risky lifestyles. Local information programs are essential not only to influence this group, but also to prevent people who have the HIV infection from being discriminated against," said Dr O'Hanlon.

AIDS first surfaced in Ireland within the prison system among inmates using drugs. Prisoners with antibodies are kept in a special facility; those who were dying of the disease were released so they did not have to die in prison. However, Ireland is trying to develop strategies for dealing with AIDS within the prison system.

Golobitsh

Protection: condom issue delayed prevention drive

Canadian cases top one thousand

OTTAWA — A further 128 Canadians are known to have developed the AIDS virus since statistics were last compiled for the period ending February 9, 1987.

The total number of Canadians reported to have AIDS is now 1,001. Of these cases, 498 are still alive, and 503 have died.

The new figures show the number of cases among intravenous (IV) drug users has increased from three to four.

Women comprised 57 of the total cases, and infants under the age of 15 months, 19.

The AIDS in Canada update was published by the AIDS Centre at the Laboratory Centre for Disease Control, Health and Welfare Canada.

'Manhattan project' revisited

WASHINGTON — A national commission has been established to advise United States President Ronald Reagan on ways of dealing with the AIDS epidemic.

He acted on bipartisan calls from US Congressional leaders who said a second 'Manhattan project' was needed in the battle to find a cure for AIDS. (The Manhattan project was the code name for development of the first atomic bomb.)

President Reagan: "The commission will help us to ensure that we are using every possible public health measure to contain the spread of the virus."

Meanwhile, US Surgeon-General C. Everett Koop, who has pulled no punches in the AIDS war, said attention must be paid not only to homosexuals and heterosexuals but also to intravenous drug users and the transmission of AIDS within the heterosexual community. He called for black and hispanic leaders to take a leading role in helping combat the problem.

WHO statistics on virus 'a fraction of total cases'

GENEVA — The World Health Organization (WHO) here has updated its statistics on the number of AIDS cases from 104 reporting countries to 48,500, as of the end of April.

The WHO called the new total a "dramatic increase" over the 33,000 cases previously reported from 101 countries (**The Journal**, March).

The United Nations organization says that the total of reported cases "represents only a fraction of the total cases to date, which are estimated to be in excess of 100,000."

The WHO estimates that five million to 10 million people are now affected by the HIV virus and that, by 1991, there will be one million AIDS cases worldwide.

LETTERS

Letters go too far on ad-ban debate

Addiction is an extremely complex field which demands tolerance of ambiguity, an openness to new ideas, and, above all, a certain intellectual humility that none of us has all the answers. Unfortunately, it is also a field which attracts more than its share of dogmatism, zealotry, and arrogance.

Perfect illustrations of the latter are two letters about tobacco advertising in the April issue, both of which go beyond debating points of disagreement with Richard Gilbert to attack his integrity and professionalism (see Gilbert, p12).

Perhaps the more offensive of the attacks comes from a representative of the so-called Non-Smoker's Rights Association (NSRA). This organization nicely fits sociologist Howard Becker's description of "moral entrepreneurs," people who are not only fanatical and single-minded about their goals but who are also essentially sophisticated hustlers, always looking for new causes to pursue and new hobby-horses to ride in order to justify their continued existence.

One need only to ask a simple question: "how are non-smokers' rights relevant to issues such as advertising tobacco products?" No doubt, they could come up with twisted logic to explain this.

Ultimately, they would like to drive tobacco completely underground, impressed, no doubt, by the success of similar policies with respect to marijuana, cocaine, and heroin, not to mention Prohibition in the United States. That goal would be far into the future, which gives the organization and their staff years of pleasurable and profitable activity.

Not only the tobacco companies have vested interests.

What I find startling and discouraging is their vitriolic intolerance of anyone who disagrees. It extends to accusations of being "ill-informed and misleading," and even to gratuitous cracks about Dr Gilbert's activity in municipal politics or giving aid and comfort to the "enemy" (tobacco corporations).

As a researcher in addictions, I find Dr Gilbert's columns to be provocative, informed, and admirably cognizant of the ambiguities which we must deal with in addressing these problems.

Sometimes I agree with his conclusions, and sometimes I disagree.

Disagreement is no excuse for *ad hominem* attacks, or verbal tantrums. Calm and rational debate should be expected from a professor of public health, although not from the NSRA entrepreneurs.

The former deserves to be reprimanded, and the latter to be ignored.

Stan W. Sadava, PhD
Department of Psychology
Brock University
St Catharines, Ontario

An Ontario warning

The Ontario Government appears ready to laugh in the face of all research and the best advice of organizations involved in the prevention of alcohol abuse.

That, at least, would be the result of an acceptance of many of the proposals submitted by the nine-member government committee investigating Ontario's liquor legislation.

Several recommendations (eg, BYOB [bring your own bottle] restaurants, round-the-clock alcohol service to hotel guests, relinquishing control of drinking at private events, and the extension of tavern hours) seem determined to increase alcohol consumption in Ontario (see p7).

With the cost of alcohol abuse already exceeding $2 billion, one wonders how much more government alcohol promotion the citizens of Ontario will tolerate.

Karl N. Burden
Executive director
Alcohol and Drug Concerns, Inc
Scarborough, Ontario

Children of alcoholics

I read the January articles regarding the Canadian Association for Children of Alcoholics (CACOA).

I have been interested in adult children of alcoholics issues for approximately two years and am associated with a Michigan group.

More recently, I attended a workshop by Sharon Wegscheider-Cruse and am interested in receiving professional training regarding the subject. I am also interested in developing a group in this area.

The articles in The Journal stated the CACOA is interested in supporting professional training and assisting people interested in developing local groups.

I am interested in both aspects and would like to know if CACOA can help.

Jacquie Dennis-Delaney
Catholic Family Service Bureau
Windsor, Ontario

* * *

I would like more information on the Canadian Association for Children of Alcoholics (January): the procedure for becoming a member, the costs, and any benefits such as newsletters.

Tom Samuel
Alberta Alcoholism and Drug Abuse Commission
Camrose, Alberta

* * *

As a result of reading your article (January) and because of prior interest in ACOA (adult children of alcoholics), I am writing for information on CACOA: books that are available, information on how to register a group, and other information.

Larry Lisitza
Alcoholism Foundation of Manitoba
Brandon, Manitoba

Welcome

The Journal welcomes a new slate of eight Editorial Board Corresponding Members from around the world.

As experts in the field of alcohol and other drug addictions and related health fields in their own countries, these new members will help keep The Journal and its readers up to date on developments in their areas.

The new members are listed in this month's masthead (below).

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A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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LIQUOR REGULATION

Drinking in Ontario—changing the rules

TORONTO — Public, media, and special interest group response to the recent report of the Ontario Advisory Committee on Liquor Regulation has concentrated on what is perceived as the liberalization of provincial regulations it recommends.

But, a policy research scientist at Ontario's Addiction Research Foundation here — who was a special adviser to the Committee — says the perception is highly inaccurate.

Eric Single, *PhD: "While the Committee's recommendations certainly involve liberalization of controls in certain aspects of the regulations, this is more than offset by recommendations that could tighten controls.*

"Server training will be mandatory: the civil liability of tavern owners will be codified. Special occasion permit events will be better controlled, as will advertising and inducements by producers."

And, Ontario Consumer Minister Monte Kwinter has announced the government will implement most of the Committee's recommendations.

The Journal *presents a synopsis of the important recommendations, followed by an analysis of the background, content, and implications of the findings by Dr Single.*

Recommendations

In presenting the report to Consumer Minister Monte Kwinter, the Committee — made up of seven board members from the Liquor Licensing Board of Ontario (LLBO), a board member from the Liquor Control Board of Ontario (LCBO), and chairman Steven Offer, member of the provincial parliament — stressed "growing public concern about the real, and potential, negative social and health consequences of the use of beverage alcohol."

After 23 public consultation meetings in 18 Ontario centres between September and November, 1986, 730 written submissions, and 205 oral presentations, the Committee said such concern "is not confined to those in the health field or to any particular age level or region of the province."

And, the report says, the changes the Committee suggests "should help promote moderation in consumption of beverage alcohol and responsible behavior related to alcohol use."

The recommendations, "designed to simplify the regulations, to remove redundancies and anachronistic sections, and to replace them with practical, understandable, and enforceable rules," include:

General values and principles

• The LLBO have a broader social perspective and use its licensing authority to pursue goals of moderation and responsibility related to the service and consumption of beverage alcohol, and this philosophy be reflected in all government policy on beverage alcohol.

• All types of beverage alcohol be treated the same under the Liquor Licence Act and regulations.

Licensing

• The existing system of licence classifications be simplified into five categories: an "A" licence for restaurants with minimum food sales of 55% of total receipts; a "B" general licence for alcohol service (with food available sufficient for a light meal); a "C" licence for unlicensed or licensed establishments to allow patrons to bring their own beverage alcohol (includes requirements for availability of full-meal menus, corkage fees, and provincial sales tax on such fees); a "D" licence for beverage alcohol delivery services; and, an "E" licence to manufacture beverage alcohol products to be available to brew pubs and other manufacturers.

• Restaurants only be required to obtain an "A" licence if located in an area zoned for this type of licence only.

• Clubs be eligible for a regular licence under the same eligibility rules.

• Municipalities which now, by municipal option, allow only certain classes of licensed establishment or types of beverage alcohol, hold a vote to decide whether all classes of licence or none will be allowed.

• Stadiums, arenas, racetracks, and other sports facilities be eligible for a "B" licence, with drinking in designated areas, patrons supervised by trained servers, and service at seats only.

Special Occasion Permits (SOPs)

• The majority of current SOP events, "socials," be forced to use a licensed establishment to serve alcohol at the event.

• Premises used to host SOP events on a regular basis obtain a licence.

• When events are in a private place (not ordinarily open to the public), for invited guests only, there is no public solicitation, and no sales of beverage alcohol directly or indirectly, no SOP be required.

Days and hours of operation

• Maximum hours of sale and service in all licensed establishments be 10 am to 2 am daily.

• "B" licence establishments be required to remain open one hour after service stops for non-alcoholic beverages/food.

• Hotels be allowed to provide 24-hour service to guest rooms and in a designated lounge for registered guests.

Legal drinking age

• The legal drinking age remain at 19 years.

• The transportation ministry create a special offence under the Highway Traffic Act to apply to probationary drivers with breath test readings more than 0.015% blood alcohol concentration, with a conviction penalty of 30-day licence suspension.

• The $53 fine for underage drinking be increased, and police officers be encouraged to proceed by summons on such charges, forcing court appearances by the accused.

• A new offence under the Liquor Licence Act be initiated charging licensees knowingly permitting underage drinking.

Beverage alcohol advertising

• All types of beverage alcohol and all advertising be subject to the same standards.

• All such advertising be consistent with a philosophy of moderation and responsibility in consumption.

• All such advertising adhere to standards such that no advertising: appeal directly or indirectly to people under the legal drinking age; appeal directly or indirectly to non-drinkers; associate drinking with driving or other activities requiring care and skill or elements of physical danger; imply consumption contributes to personal or social success; or, appear to reinforce behavior which can lead to adverse health or social consequences.

• Beverage alcohol manufacturers be required to dedicate a significant portion of advertising/promotion budgets to public service ads to educate the public on the potential hazards of alcohol consumption.

Inducements and promotions

• Inducement regulations apply to all beverage alcohol manufacturers whose products are sold or promoted in Ontario, including their distributors, agents, and related people.

• Inducements be prohibited and regulations be clarified and strengthened to enforce prohibition.

Civil liability

• An exclusive statutory remedy for liability pertaining to overservice of alcohol and service to underage people be instituted, be fault-based, encompass death or injury to the alcohol consumer or third parties, and cover all providers of beverage alcohol for sale and all providers of alcohol in public places.

Education

• The LLBO set minimum standards for mandatory training programs for all beverage alcohol servers and expand its training seminar for new licensees to include all licensees and managers.

• A proportion of LLBO revenues be designated to a continuing alcohol education program, with emphasis on youth.

• The LLBO provide an effective information service to licensees and the public and have a communications budget.

LCBO issues

• The LCBO carry de-alcoholized beer and wine and distribute educational materials on alcohol at the point of sale.

By Eric Single

The report of the Ontario Advisory Committee on Liquor Regulation was made public on March 3, 1987. It detailed some 70 recommendations which, taken together,

Single: sweeping transformation

would represent a sweeping transformation of provincial liquor laws.

The Committee was appointed by Consumer Minister Monte Kwinter in June, 1986.

It was mandated to examine the general philosophy and values which should be ingrained in the Liquor Licence Act, the types and nature of licences and permits, classes of premises to be licensed, days and hours of operation, suitability of the legal drinking age of 19 years, and suitability of forms of advertising. The terms of reference explicitly omitted: beer and wine in corner stores, pricing and tax structure of alcoholic beverages, and national/international trade implications.

The Report

• **General philosophy:** The Committee adopted the position that access to alcohol is a "limited right." The limitation of individual rights is justified on the grounds that alcohol represents a major drug problem to society: revenue is secondary.

There is a great deal of concern expressed about the promotion of responsible drinking practices.

The disease concept is rejected as the sole basis for alcohol policy: "Although the problem of alcoholism is a serious concern for government, alcohol problems encompass a great deal more than just the person who is physically dependent on alcohol."

Despite the liberal predisposition of the Committee, there was a clear rejection of the simplistic reasoning that government policy should consist of unrestricted access to alcohol for the majority, combined with the provision of treatment for the minority who develop problems.

• **Licence classification:** The Committee recommends a major reclassification of types of licences. There are currently 12 types under the Liquor Licence Act and its regulations: lounge, dining lounge, dining room, entertainment lounge, public house, club — lounge, club — dining lounge, patio, hospitality, manufacturer's, stadium, and brewpub.

Each type has a list of permissible premises, as well as other special stipulations.

Perhaps the most essential feature of the special stipulations is the sharp distinction between eating and other establishments. In dining lounges, dining rooms, and club-dining lounges, minors are permitted on the premises, and alcohol can be served on Sundays. On the other hand, these establishments are subject to 40/60 food/beverage ratio requirements plus a number of detailed regulations on availability and service of food.

These rules, particularly permitting Sunday hours for dining establishments, may largely account for the highly skewed distribution of licences.

The table (Fig 1, next page) presents the number of different classes of licences in the 11,840 licensed premises in Ontario. The special categories of brewpubs, hospitality, and manufacturer's licences are not included.

The most prevalent type of licence is the dining lounge; nearly three out of four licensed establishments in Ontario currently hold a dining lounge licence. At the other extreme, only 54 establishments hold entertainment lounge licences.

These figures tend to corroborate claims frequently aired during the public hearings that many establishments are misclassified as dining lounges.

Another category with a low number of licences is the public house licence. The decline in numbers reflects both a trend toward fewer old-fashioned, open-styled,

LIQUOR REGULATION

Drinking in Ontario

(from page 7)
austere beer parlors, and the fact that many of the remaining public houses have opted for lounge licences in order to serve spirits. This classification was viewed as anachronistic and unworkable.

The Committee proposes a new classification in which most establishments would receive a general licence to sell alcohol, with no special classes for entertainment, pubs, transportation venues, brewpubs, stadium, or other special venues.

Food would have to be available at all licensed establishments.

There would still be a licence for restaurants, but only in those areas zoned for this type of licence only. The licence would carry no special privileges (such as Sunday sales) and would require a 55/45 food/beverage ratio. It is anticipated few municipalities would zone for these licences only, so most restaurants will obtain the general type of licence.

A new bring your own bottle licence is proposed whereby patrons could bring their own alcohol, pay a corkage fee, and have the licensee serve the alcohol. The licensee would be responsible legally for the service of alcohol and would be required to attend a training course.

It is difficult to judge what the likely impact of these proposed changes would be. Currently, the vast majority of establishments hold dining licences even though many are not truly eating establishments. This widespread fiction has led to many administrative problems, most notably the doctoring of account books to conform to the food/beverage ratio requirements.

But, it has also had positive benefits. The forcing of hybrid establishments — part taverns and part food establishments — to pretend to be restaurants undoubtedly led to the promotion of food with alcohol consumption and the structuring of drinking environments that promote moderation.

On the other hand, the new regulations would require food (light meals) be available in all premises, and servers would be trained in responsible beverage service. Only time will tell the next impact of the new rules on drinking establishments of Ontario.

• **Special occasion permits (SOPs):** SOP functions represent a major source of drinking problems in Ontario.

There are more than 150,000 permits issued annually, the majority for "socials" where alcohol was supposedly sold solely to recover costs. Other special permit events include weddings, receptions, fundraising events by charitable and educational organizations, and community festivals.

The problems mainly concern irresponsible conduct of the events, particularly the overservice of alcohol and service to minors. Another problem is unfair competition with licensed establishments, which are subject to a great deal more regulation and are much more accountable for improper conduct.

A major cause of the problems is the lack of inspections.

The Committee recommends sweeping changes to the system for providing SOPs: organizations which hold events on a regular basis would be required to obtain a licence; "social" events would no longer be permitted to obtain a special permit. Instead, they would have to either use a licensed establishment or hire a licensee to serve alcohol at the events.

On the other hand, no-sales receptions, which currently require a permit, would be allowed without a permit provided that alcohol is not sold directly or indirectly and the attendance is limited to invited guests.

Provision would be made for a regular inspection of events.

• **Days and hours of operation:** Currently, all licensed establishments may operate between 11 am and 1 am, Monday through Saturday, and dining licences may operate on Sundays, between noon and 10 pm.

The hospitality industry has lobbied long and hard for an extension of operating hours and Sunday sales, citing problems in border areas where neighboring jurisdictions have later closings, competition for tourism, and the public demand for extended hours.

The Committee recommends an increase of maximum hours of operation to the 10 am to 2 am seven days a week. Municipalities would be able to restrict these hours, and all licensees would be required to remain open one hour after "last call" and make non-alcoholic beverages available during that hour.

• **Drinking age:** Perhaps the most salient issue in the public hearings was the drinking age issue. Public health agencies and citizen groups argued for raising the drinking age to 21 years, mainly on the grounds that this would reduce drinking and driving accidents among young drivers.

In the United States, federal legislation enacted in July, 1984 withheld highway grants to states which did not raise the drinking age to 21 years by October 1, 1986. All but four states complied. Positive evaluations of these changes added impetus to the call for raising the drinking age.

On the other side of the issue, student groups and the hospitality industry lobbied against raising the drinking age. The reasons they cited include potential border problems with neighboring provinces which have a lower drinking age, discrimination against non-driving youth and responsible youth, and the success of campus alcohol education programs in reducing drinking and driving problems.

The Committee takes a compromise position: it was unwilling to recommend raising the drinking age; even though it is likely that this would reduce drinking and driving among teenagers, it is felt this would be discriminatory toward responsible youth. A further consideration is that the highest rates of impaired driving occur among drivers between 21 and 35 years.

On the other hand, the Committee has proposed a special standard for the provincial drinking and driving offence for probationary drivers. During that period, there would be an automatic licence suspension for driving with a blood alcohol concentration (BAC) of 0.015%. This contrasts with the BAC level of 0.08% for other drivers.

The Committee also recommends stiffer penalties for underage drinking, thus putting the focus on the problems associated with youthful drinking rather than the prohibition of drinking among teenagers.

• **Advertising:** Particular concern was raised about the increase in so-called 'lifestyle' advertising, which associates alcohol consumption with good times, sexual success, and popularity.

The Committee recommends more stringent requirements on the content of advertising, with specific prohibitions against appeals to youth and the association of alcohol with activities requiring care or skill or physical danger. Perhaps the most significant recommendation is the proposal that a significant (but unspecified) portion of advertising budgets be spent on public service messages warning the public about the hazards of alcohol consumption.

• **Inducements and promotions:** The regulation of inducements and promotions is somewhat confused. The LLBO controls promotions and has been publicly criticized for outdated restrictions against virtually any ties between licensees and producers.

An example frequently cited as indicative of the need for bringing the Liquor Licence Act into conformity with modern times was the prohibition against patio umbrellas which advertise alcoholic beverages. On the other hand, the LCBO, responsible for certain aspects of promotion by alcohol producers, has permitted large outlays for free distribution.

The Committee recommends changes which would reverse this situation, restricting inducements but permitting legitimate promotions.

An inducement is defined as an act by a manufacturer which persuades a licensee to carry more of that manufacturer's products than the normal marketplace would dictate. Promotions are targeted at persuading consumers to try a product.

• **Civil liability:** The Committee considered a broad range of issues concerning the civil liability of people who provide alcohol for damages and injuries caused by intoxicated people to others.

There has been a dramatic increase in the number of lawsuits against licensed establishments and in the size of damage awards. The LCBO is being sued for serving an apparently intoxicated person who is alleged to have subsequently caused a traffic accident. A further reason for considering liability issues is that civil liability can be used to influence the behavior of people who serve alcohol.

The current legal environment governing the service of alcohol is extremely complex, involving the penal provisions of the Liquor Licence Act, statutory liability, common law liability, and liability under the Occupiers Liability Act of Ontario.

A detailed analysis of the existing lawsuits and liability issues revealed a number of problems with this complex legal environment: the boundaries between statutory and common law actions are blurred, and, even when taken together, do not provide a comprehensive course of action. Civil liability provisions do not adequately reflect the penal philosophy of the Act.

Perhaps most importantly, current liability imposes an unfair and impractical standard of conduct on licensees and alcohol providers.

Under current law, a server may be held liable for serving someone past the point of intoxication even in circumstances where he or she acted reasonably to try to determine a patron's state of sobriety.

The Committee attempts to redress this situation by proposing the current statutory provision of liability be replaced by a comprehensive, exclusive remedy which is fault-based and therefore consistent with other types of negligence actions.

Servers' liability would be restricted to situations in which they knowingly or negligently serve a minor or serve a person past the point of intoxication (0.08% BAC). This means responsible serving practices of a licensed establishment could be entered in evidence.

A tavern owner who monitored his door, trained his staff in responsible beverage service, and had house policies aimed at preventing intoxication could argue he did everything he could reasonably be expected to do to prevent an intoxicated person from being served.

The codification of civil liabilities under common law would do much to end current confusion. Tavern owners would be liable for damages caused by underage or intoxicated patrons, but they would also be provided with guidelines.

• **Education:** There has been a number of server intervention programs developed over the past three years.

The LLBO provides a half-day workshop for new licensees and transfers. It covers LLBO regulations and procedures as well as information on how to recognize and prevent intoxication from a server-training program from the Addiction Research Foundation (ARF).

In addition, hospitality industry organizations and individual licensed establishments have developed training programs.

The Committee recommends all servers in the province be required to take a training program as a condition of employment in the hospitality industry. Course content and standards would be developed by the LLBO, in collaboration with the ARF.

The training itself would be carried out by the ARF, the community colleges, and private organizations which meet the standard. Eventually, some 100,000 people would be trained.

The Committee recommends increased government expenditure for alcohol education, particularly for schools.

• **LCBO issues:** The focus of the Committee report is on the LLBO and regulations concerning the service and sale of alcohol in on-premise outlets. However, certain recommendations concern the LCBO, which controls off-premise sales.

It is proposed that the LCBO carry out its mandate in a manner which is consistent with the goals and philosophy of the LLBO and the Liquor Licence Act. Specifically, the Committee recommends that the LCBO stock de-alcoholized beverages in its stores, that its advertising conform to the standards set by the LLBO for manufacturers, and that it distribute educational materials on the potential harmful effects of alcohol.

It recommends the LCBO be renamed the Alcohol Marketing Board and the LLBO the Alcohol Licensing Board to more accurately reflect their purposes.

Fig 1 — NUMBER OF LICENCES AS OF SEPTEMBER 2, 1986

	Number	As % of All Licences	As % of Establishments
Lounge	2,103	12.8%	17.8%
Dining Lounge	8,617	52.7%	72.8%
Dining room	1,141	7.0%	9.6%
Entertainment Lounge	54	0.3%	0.5%
Public House	62	0.4%	0.5%
Club — Dining Lounge	475	2.9%	4.0%
Club — Lounge	1,328	8.1%	11.2%
Patio	2,582	15.8%	21.8%
Stadium	4	*	*
TOTAL	16,366	100. % (16,366)	138.2%** (11,840)

* *Less than 0.05%*

** *Totals more than 100% because many establishments have more than one type of licence*

'The bulk of recommendations involve tightening of alcohol restrictions'

Reaction to the Report

As might be expected, the report has generated a large volume of publicity and public reaction. The press coverage focused on those recommendations which involve a liberalization of controls, such as the Bring Your Own Bottle licence, the extension of operating hours, and the permission of alcohol in theatres.

This portrayal of the report as a package of recommendations for liberalizing access to alcohol in Ontario is highly inaccurate; the bulk of the recommendations involve tightening of alcohol restrictions.

Nonetheless, based largely on press reports, a wide variety of opinion has been expressed. Negative reactions were voiced by the brewers and by community groups (see p6).

More neutral reactions, favoring some recommendations while criticizing others, were voiced by public health professionals, the police, and municipalities.

Positive reactions were expressed by the press, the distillers, many licensees, and hospitality organizations

Perhaps most importantly, the government has endorsed the recommendations and the consumer minister has announced that the government will implement of most.

VOL. 1 NO. 1 JUNE 1987

Premier Issue

this new
ication regularly,
tarting in September.

ADDICTION RESEARCH FOUNDATION'S
ONTARIO REPORT

"Drug problems are truly pervasive in Ontario," says Dr Michael Goodstadt, Head of ARF's Education Research Program.

Dr Goodstadt's comments on ARF-sponsored poll on page 2.

New 5 year $210 million program

National drug strategy holds real promise

Dr Joan Marshman

TORONTO – On May 25, Health and Welfare Minister Jake Epp launched the long-awaited National Drug Strategy, a five-year plan to help curb drug abuse in Canada. The federal plan commits $210 million new dollars to initiatives in public education, treatment and rehabilitation, law enforcement and control, research and international cooperation.

"The federal program can make a significant contribution to the alcohol/drug abuse field in Ontario," comments Dr Joan Marshman, President of the Addiction Research Foundation. "It appears to be complementary to the programs and priorities in the province. Certainly, it helps complete the continuum of government commitment to dealing with these issues."

The Ontario government has a long history of involvement with alcohol and drug issues. It has funded the ARF's work in research, treatment, prevention and public education over the past 38 years. In the last five years, the government has focused on the network of community treatment services and, increasingly, in the area of health promotion. In the April Speech From The Throne, the government announced plans to further support treatment services for youth and to promote a drug-free lifestyle in the province.

Partnership with the provinces forms a cornerstone of the federal government's return to the drug abuse field. "To succeed," Mr Epp said, "all those who are a part of the solution must work in partnership so that all efforts dovetail into a comprehensive, practical program."

The launch of the National Drug Strategy follows months of research and consultation with professionals and volunteers across the country. The ARF played a major role on behalf of Ontario. As chairman of the Federal/Provincial Advisory Subcommittee On Alcohol And Other Drug Problems (recently changed to an Advisory Committee), Dr Marshman helped to frame recommendations to Health & Welfare on needs in the areas of education, prevention and treatment. In addition, ARF senior staff were consulted by numerous federal officials directly, and facilitated dialogue with community leaders from all parts of the province.

The announcement included a breakdown of spending plans by issue area and by year. 39% will go towards treatment and rehabilitation, 33% for education and prevention, 19% for enforcement and control, 5% for research and the balance for national coordination and international cooperation. This fiscal year, $20 million will be spent. Next year the figure will rise to $40 million, and to $50 million for the following three years.

The inclusion of alcohol, solvents, prescription and over-the-counter drugs, along with illicit drugs, indicates, according to Dr Marshman, an appreciation of the breadth and depth of drug abuse in Canada. She was impressed with the support to community-based initiatives. "It encourages a sense of ownership and involvement at the grassroots level."

In addition, Dr Marshman sees the federal monies allowing for a significant enhancement of treatment services and for the funding of a major media campaign to influence the social climate, a valuable new dimension to existing efforts that couldn't be done otherwise.

"At this point we don't know precisely how much of this money will be available for Ontario," said Dr Marshman. "Consequently, it is difficult to know precisely the degree to which Ontario will benefit. As for the strategy as a whole, it reflects the advice that was offered by the ARF and the other alcohol and drug agencies in commissions from the other provinces and territories. "We're looking forward to being actively involved in the further development and in the implementation."

The ARF is already working on behalf of the Ontario government to help refine the federal/provincial formula for cost-sharing in treatment services. As chairman of the Federal/Provincial Advisory Committee, Dr Marshman anticipates having significant input, along with her colleagues from across the country, on the details of the program. She anticipates that the ARF will be able to help frame some of the research questions.

Within Ontario, the ARF plans to continue its cooperative efforts in public education, including coidentification on the advertising campaign to begin in June. At the community level, ARF regional offices will be working with community groups to help them develop proposals for federal support.

According to Dr Marshman, Mr Epp's announcement holds considerable promise for the alcohol/drug field in Ontario. It adds momentum to what is already a growing social issue. "It delivers an important message to the public: that we can change things – and we are going to do so."

New focus on Ontario from ARF

Welcome to the premier issue of the **Addiction Research Foundation's Ontario Report**, a new publication for those involved in the alcohol and other drugs field in Ontario.

This new publication has been created to meet the special needs of Ontario readers.

In February, the Addiction Research Foundation (ARF) surveyed a number of its clients and readers of **The Journal.** You may have been one of the respondents to the survey who requested that the ARF provide more information to highlight developments, issues, and events in the field of alcohol and other drugs of special interest to Ontarians.

ARF's Ontario Report will help you keep abreast of these issues, trends, and developments. It will help you keep track of the activities of individuals and organizations working throughout Ontario: what they're involved with, and what it means to you.

Further, the publication will keep you in touch with the activities of the ARF: progress on the research front; innovations in treatment and rehabilitation that have utility in Ontario; new prevention policies and programs; new information and education resources designed to expand public knowledge and shape individual behaviour.

This issue features articles of special interest to Ontarians: a new national drug strategy; highlights of an ARF-sponsored study on alcohol and other drug-related issues; introduction of ARF's newly upgraded Drug and Alcohol Information Line; employment-related drug-screening issues; a new media campaign targeted at young drivers; and, *Insight*, a regular column by ARF's President Dr Joan Marshman.

In short, **ARF's Ontario Report** is a publication with a mission: to provide people with what they need to know to play a more effective role in the alcohol and other drugs field in Ontario.

This first issue is an introduction to a regular publication which begins in September. Editors of **ARF's Ontario Report** welcome Letters to the Editor, comments, and suggestions on the first issue.

IN THIS ISSUE

INSIGHT

THE TIME HAS COME

It looks as if the time may have come, finally, for a concerted effort to overcome the problem of alcohol and other drug abuse in Canada. The indicators are everywhere, signalling dramatically increased concern among governments and the public alike.

The Ontario government, in the April Throne Speech, committed itself to expanded efforts to make this province a healthier place to live — to promoting a drug-free lifestyle, and to increasing accessibility to treatment services for young people. On May 25, the Honourable Jake Epp launched the National Drug Strategy which allocates new federal resources and greater support for the work of those already in the field, including the provincial alcohol and drug foundations and commissions across the country.

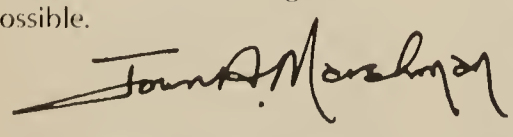
As for the public, I doubt there's ever been a more receptive social climate in this province. The highlights of the Addiction Research Foundation's (ARF's) recent Ontario poll demonstrate that people are aware of and deeply concerned about the issues: problem drinking (drinking and driving in particular), and the use of drugs like cocaine, heroin, and cannabis. Even the abuse of prescription drugs is a recognizable concern for people at this time.

It is encouraging to see substance abuse high on the societal agenda. Years of effort from professionals and volunteers are finally paying off. But, it is not quite time to celebrate. It is certainly no time to become complacent. And, it is not the occasion for us to take the skeptic's view that neither government nor public concern will be sustained for the long haul — the generation it will take to achieve fundamental change.

Rather, circumstances demand that all of us in the alcohol and other drug field address ourselves to a single question: how do we translate this awareness and concern into effective action? Society is going to be looking to us for direction. It is vitally important that we provide it.

Are we ready to meet the challenge? I can answer for the ARF in the affirmative. We have committed ourselves to playing our role in Ontario more effectively and more dynamically in the next few years: to increasing our understanding of alcohol and other drug problems; to fostering improved treatment and rehabilitation services in the province; to accelerating the implementation of pragmatic prevention policies and programs; and, to applying new strategies to our public education and information programs.

At the ARF, we believe the opportunity to make a real difference is upon us. We are working to ensure that the new societal interest and the new resources from government are utilized to maximum advantage. I encourage everyone in the field to do the same. It will take the concerted efforts of us all to achieve the kind of change that circumstances now suggest is possible.



Joan A. Marshman
President, ARF

ADDICTION RESEARCH FOUNDATION'S
ONTARIO
REPORT

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Drug Abuse in Ontario —

Surprising unanimity of opinion

The abuse of alcohol and other drugs ranks among the leading issues for the people of Ontario today, according to an ARF sponsored poll. During February and March, a representative sample of 1,086 Ontarians over the age of 15 years were surveyed by telephone on a variety of drug-related issues. The results, with a margin of error of +/−3% at a 95% confidence level, provide an overview of how people in Ontario perceive drug problems.

Impaired Driving #1

"People are aware of and deeply concerned about drug-related issues," explained Dr Michael Goodstadt, Head of ARF's Education Research Program, in a presentation to the House of Commons Standing Committee On National Health and Welfare. The Commons Committee held public hearings in Toronto on May 20 and 21 as part of its extensive examination of drug abuse issues.

Impaired driving and eliminating the use of hard drugs, such as cocaine and heroin, ranked highest of the nine prominent issues investigated in the poll. 87% said they were very concerned with reducing drinking and driving; the use of hard drugs such as heroin and cocaine was of serious concern to 82%. By comparison, reducing air and water pollution was a serious concern to 76% of respondents. Reducing the use of cannabis was a serious concern to 67%, ranking significantly above the harmful effects of smoking

Facts about drugs and related issues

TORONTO — The Addiction Research Foundation's (ARF's) popular Dial-A-Fact service has been revamped to better serve the information needs of people across the province.

First, there's a new name; from here on, the service will be known as the **ARF's Drug and Alcohol Information Line.** Second, the service itself has been expanded; and, finally, an extensive promotional campaign has been developed that will enable the Foundation to make more Ontarians aware of the service and how to access it.

Since its creation in 1983, Dial-A-Fact has proven a popular and cost-effective means of providing the public with responsible information on a variety of alcohol and drug-related topics.

In 1986, the Ontario Ministry of Health provided a grant to the ARF to expand the service and to promote it more aggressively across the province. Market-research with people across the province helped identify ways and means by which both objectives could best be achieved.

The new name will help people understand immediately what the service offers. More tapes have been added on topics of interest, and the French service has been enhanced considerably.

What has not changed, however, is the way the telephone service works. From 9 am to 9 pm bilingual operators staff the phone lines and connect callers with tapes on one of over 60 alcohol and drug matters and issues of family and personal health.

For Toronto area callers, there is a local number: **595-6111. Outside of Toronto,** callers access the service toll free by calling **1-800-387-2916.**

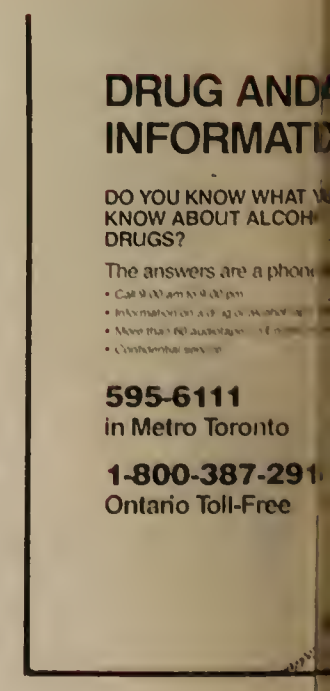
That call is made by approximately 75,000 people each year. The ARF anticipates calls will increase considerably over the next 12 months as a result of a new promotional campaign that begins this month and continues throughout the year.

The theme of the campaign is, "It's For You." It is an ambitious effort designed to reach people of all ages in many different ways.

This summer, the ARF will distribute take-away fliers through counter displays at LCBO outlets and Brewers' Retail stores.

In the fall, schools across the province will receive promotional packages for students, including bulletin board posters, counter racks, and information leaflets. Regional offices will help coordinate an extensive public service campaign on public transit systems in several communities.

Additional public service materials are being provided to magazines and newspapers across the province as well.



More tha

The Information Line ha
audiotapes available
French on a wide range
other drug topics, such

Facts on alcohol
Facts on drugs
Alcohol and drug issues
Family concerns
Health concerns for wo
Special concerns about
alcohol use
Treatment

A Major Public Concern

and equal pay for men and women, both of which were of serious concern to 57% of respondents. Fully 50% expressed serious concern about improved control of prescription drug abuse.

indicated codeine and like painkillers, and 44% mentioned ASA. It was surprising to discover that 23% of 15-24 year olds identified codeine and similar painkillers as the drug most abused in their community.

"People are aware and deeply concerned about drug-related issues"

"The uniformity of opinion is surprising," Dr Goodstadt said. "On the impaired driving issue, for example, more than 80% of all the subgroups defined by age, sex, region, education, employment and ethnic background, were very concerned."

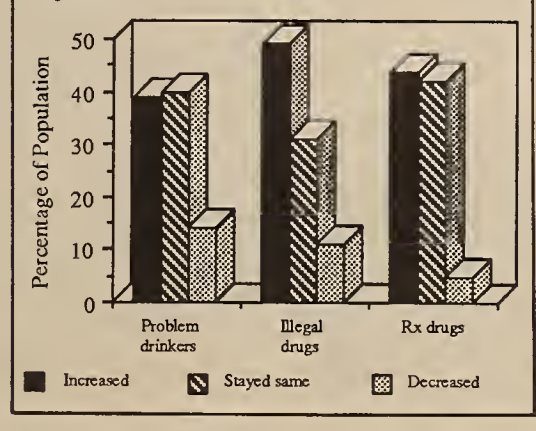
Perceptions of drug problems are attenuated somewhat when people focus on their own community as compared to society as a whole. For example, of the 72% of all respondents who thought at least one illegal drug is being used in their community, 50% believe that marijuana is causing the greatest problem, while 24% believe it is cocaine/crack. The situation is seen differently in Metro Toronto, where cocaine/crack was identified by 37% as the leading drug problem; 33% indicated cannabis.

The abuse of prescription and over-the-counter drugs is a greater concern than would be expected, according to Goodstadt. 60% of respondents believe at least one prescription drug is being widely abused in their community, with valium and other tranquillizers cited by 69%, followed by sleeping pills (56%) and diet pills (47%). Among over-the-counter drugs, 55%

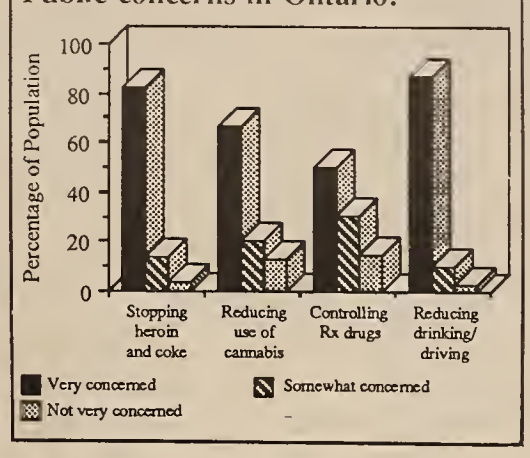
Not Getting Better

While some research on trends of drug abuse indicates declining consumption by some population segments, people across the province who identify drug abuse as a problem in their community do not believe the situation is improving. In fact, 49% think illegal drug use has increased in their community over the last five years. Further, 44% hold the same view on prescription and over-the-counter drugs. The number of problem drinkers has increased in their community in that time, according to 39% of respondents.

People's perceptions re: alcohol/drug problems over last 5 years:



Public concerns in Ontario:



Problems Are Pervasive

Goodstadt pointed out that perceptions of drug problems are influenced by many factors, particularly the level of media attention they receive. The poll indicates clearly, however, that people have personal contact with these problems. 60% say that a family member or close friend has had a problem resulting from alcohol use; 24% report personal contact with someone who has had a problem with illegal drugs; 17% report a family member or friend who has had a problem resulting from prescription and/or over-the-counter drugs.

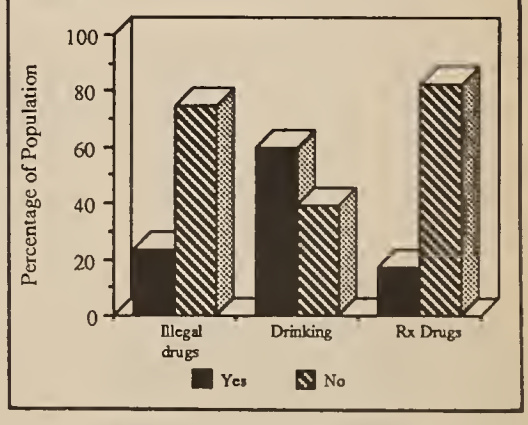
"Taken together, these results indicate that drug problems are truly pervasive in Ontario," Goodstadt concludes. "One shudders to think what the numbers would look like had it not been for the on-going efforts of people working in the alcohol/drug field."

He noted that many of the public's perceptions related to problem drinking and the use of illegal drugs are to be expected. The level of concern over prescription and over-the-counter drugs is surprising. There is evidence of exaggerated levels of concern regarding the levels of drug use, especially in relation to cocaine and crack.

Basis for Action

"It is striking to see the high levels of consensus among all types of people in terms of their concerns and perceptions of the problems," Goodstadt said. He indicated that the survey will help the ARF to identify the public's perceived needs in the drug area and to assess potential public support for interventions designed to help people prevent and combat problems.

Personal contact with individuals who have/had problems with:



"We expect to learn a great deal more from this poll as we study the results further," Goodstadt explained. "How the people of Ontario perceive matters in the drug area is of pivotal significance."

60 tapes available

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A complete list of topics is available from the Information Line operator.

Transcripts of any of these messages can be obtained by sending $1 per transcript, along with your name, address, and the code number of the tape to:

Information and Promotion
Addiction Research Foundation
33 Russell Street
Toronto, Canada M5S 2S1.

Program aims to curb drinking driving

Media campaign targets young drivers

TORONTO — On May 13, the Addiction Research Foundation, in cooperation with Health and Welfare Canada, launched the Ontario phase of a new media campaign on drinking and driving — *Play It Smart/J'ai Toute Ma Tête.*

The campaign marks the beginning of the long-term national program on impaired driving announced the same day by Health Minister Jake Epp. Over the next five years, the federal government has committed $19.5 million to the program.

"As an agency of the Province of Ontario, we are extremely pleased to be part of the campaign," says Joan Marshman, PhD, ARF president. "It adds an important dimension to existing efforts to reduce impaired driving in this province, such as the drinking/driving Countermeasures program organized by Ontario Ministry of the Attorney-General. It also fits perfectly with the ARF's existing efforts in this area."

The campaign features television and radio ads aimed at people aged 16 to 24 years — the drivers most frequently involved in alcohol-related accidents. Although this age group accounts for less than 17% of Ontario's licensed drivers, 40% of the drivers involved in alcohol-related accidents are between 16 and 24 years.

The ARF played a significant role in the development of the campaign. "We worked as part of the national committee that determined the target group, the messages, and the timing of the campaign," explains Henry Schankula, ARF's director of education resources.

PLAY IT SMART
WHEN YOU DRIVE DON'T DRINK

"We are delighted to see it going to work this summer."

Play It Smart/J'ai Toute Ma Tête ads are scheduled to correspond with holiday weekends, traditionally periods of high accident levels. (Victoria Day weekend in 1985 saw one person killed or injured every hour in Ontario.)

Studies conducted by Health and Welfare Canada indicate that 50% of young people drive after drinking. The campaign will help convince people that this behaviour is socially unacceptable.

Information from the ARF's recent poll in Ontario indicates that people are, in fact, getting the message. Fully 68% of Ontarians indicated that they notice their friends have become much more careful not to drink and drive.

"That's encouraging, but it is certainly no reason for complacency," comments Dr Marshman.

"The estimate that it will take up to 20 years to dramatically change current drinking and driving habits is realistic when we consider how long it took to convince people to stop smoking."

Future plans for the long-term national program include support for community-based activities and server training programs, both areas in which the ARF is already active.

ARF regional offices are currently working in communities across the province on a variety of projects on drinking and driving. The ARF server intervention program, endorsed by the Ontario Ministry of Consumer and Corporate Relations, assists the hospitality industry by teaching licencees and employees a responsible approach to serving alcohol.

"We commend Mr Epp for making such a commitment," says Dr Marshman. "The ARF is looking forward to continuing cooperation and involvement in the program."

THE FACT FILE

What are the odds?

In any one particular year, the average Ontario adult has a:

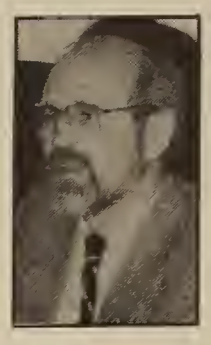
- **nine in 10 chance of being an alcohol consumer**
- **one in 10 chance of being a problem drinker**
- **one in 32 chance of being an alcoholic**
- **one in 3,333 chance of dying as a direct result of an alcohol problem**
- **approximately a one in 3,260,000 chance of winning the grand prize in any Lottario draw.**

Workplace drug screening: solution or intrusion?

TORONTO — Employee-related drug screening could become one of the most contentious issues in labor/management relations over the next decade. The issues are complex. Who should be tested? How? When? Who should get the results? What action should be taken when results are positive?

The ARF has adopted a multi-faceted approach to help people in Ontario deal with these and related questions. A special ARF Task Group has released the results of its in-depth study of the topic. ARF's employee-assistance consultants are now prepared to discuss the report with employers and labor groups across the province. As well, a series of ARF-sponsored workshops is planned to provide in-depth information for organizations considering drug-screening programs for their employees.

The Task Group report covers three key areas: public health and safety, drug-screening methods, and legal issues. It concludes that mass or random screening for either current or prospective employees not be implemented. However, if an



Bruce Cunningham, chairman, EAP Task Force

employee exhibits deficiencies in job performance or behaves at work so as to create a safety risk to others, drug-screening might be considered. In such cases, the individual should be referred to a doctor who can assess the situation and make the decision on whether to conduct the tests.

Pre-employment screening or random screening could be considered for people whose jobs pose a risk to coworkers and/or to the public and who are unsupervised for periods such that evidence of impairment wouldn't normally be observed.

It is vital, the Task Group points out, that if drug-screening is instituted, proper procedures are followed to ensure results are valid, accurate, and completely confidential. An employee whose test proves positive should be referred to an employee assistance program for assessment and rehabilitation, if it is needed.

Before any employer institutes drug screening, a formal policy should be drawn up stating the reasons why testing is being instituted and spelling out what will happen to an employee who tests positive.

Finally, the ARF Task Group urged employers to consider the value of other approaches to combating the risks of alcohol and drug abuse in the workplace: health education and employee assistance programs, regular performance appraisals, and security checks. Such efforts are most effective when instituted with cooperation between labor and management.

The issue of employee-related drug screening far from resolved, ARF's intention is to provide people in Ontario with ready access to the information they need to make responsible decisions.

The key findings of the Task Group have been published as a **BEST ADVICE** paper which is available at no cost through all 30 Regional offices or through: **Information and Promotion, ARF, 33 Russell Street, Toronto (416) 595-6101.**

ARF's 31 EAP consultants are available to discuss the Task Group's report with both current client groups and other interested groups.

EAP CONSULTANTS AND COMMUNITY CONTACTS

Area	Contact Person	Telephone Number
Barrie	Gloria Romanic	(705) 726-4976
Burlington	Peter Marks	(416) 632-2436/38
Chatham/Sarnia	Pat Allan	(519) 354-1000
Cornwall	Peter Barkway	(613) 932-3300 Ext. 238
Hamilton	Rick Csiernik	(416) 525-1250
Kenora	Leonard Byron	(807) 468-6372
Kingston	Roy Tear	(613) 546-4266
Kitchener	Dave Coleman	(519) 579-1310
London	Michael Grace	(519) 433-3171
Mississauga	Frank Fallon	(416) 270-1431
North Bay	Ginette Goulet	(705) 472-3850
Oshawa	Bob Finlay	(416) 576-6277
Ottawa	Charles Ponee	(613) 224-3604
Owen Sound	Dave Docherty	(519) 371-1861
Pembroke	Larry Sobol	(613) 735-1023
Perth	Christine Bois	(613) 267-1152
Peterborough	Brian Mitchell	(705) 748-9830
Sarnia	Angelina Chiu	(519) 337-9611
Sault Ste Marie	Michael O'Shea	(705) 256-2226
Simcoe	Toby Barrett	(519) 426-7260
St Catharines	W. Kernahan	(416) 685-1361
	Barry Dunbar	(416) 683-1361
Sudbury	Lucien Mageau	(705) 675-1195
Thunder Bay	Bob Bishop	(807) 622-0607
Timmins	Betty Findlay	(705) 267-6419
Toronto	Bruce Cunningham	(416) 595-6046
	Wilfred Orgias	(416) 595-6028
	Carol Ann Curnock	" "
	Pat French	" "
	Judy Keaney	" "
Windsor	Harry Hodgson	(519) 253-1146

NEW from ARF

Drugs and Drug Abuse

Second Edition

A single, concise, intelligible, and readily available source of knowledge in the alcohol and drug field. The first edition of *Drugs and Drug Abuse*, compiled by scientists at the Addiction Research Foundation, filled the need for specific and detailed knowledge of the field for people in hospital emergency departments, police, judges, lawyers, social workers, teachers, and the general public.

The second edition reflects the rapid changes in the patterns of street drug use, such as adding an enlarged chapter on cocaine and crack.

The scientific information about drugs and their abuse has been evaluated, digested, and translated into accessible language for the non-specialist.

For more information or to order: *Marketing Services, Department OR, Addiction Research Foundation, 33 Russell St, Toronto, Ontario M5S 2S1. (416) 595-6056. $29.50.*

EAP Analyst

Just released, an exciting new software package to help Employee Assistance (EAP) managers monitor their programs and produce hard data quickly and easily.

Produced by People and Profits (a division of Central Canada Grocers and part of Loblaws Companies Ltd) in cooperation with the Addiction Research Foundation (ARF), this package has been called "a state-of-the-art tool which will revolutionize the employee assistance field."

Whether you have an established EAP program to assist employees with personal problems, including alcohol and other drug problems, or are considering starting one, the *EAP Analyst* can help.

For more information *contact your local ARF office; or Wilfred Orgias, Centre Director, Metro Employee Assistance Programs Centre, Addiction Research Foundation, 175 College St, Toronto, Ontario M5T 1P8; or Gordon Brandt, Manager, Marketing and Technical Development, People and Profits, 22 St Clair Ave E, Toronto, Ontario M5N 2K3.*

What When Where

Safe and Sober Boater Program — May 27 through mid September, Northwestern Ontario. Implemented by the Addiction Research Foundation (ARF) Kenora Centre in conjunction with the Ontario Provincial Police and the Ministry of Natural Resources, the project targets the 45,000 boaters in the region. Spot and safety checks are used to monitor impaired boating. For further information, call Melissa Rael-King, ARF Kenora office, (807) 468-6372.

Project Aware — aired twice weekly (Sundays and Tuesdays) beginning June 14, Timmins. This 14-part television series dealing with addictions is a co-production of the ARF Timmins Centre and Northern Cable (Channel 12). It focuses on health promotion and treatment issues.

Server Training Intervention — June 15, Oakville. The owners and employees of approximately 60 licensed Oakville establishments will participate in a server training program aimed at reducing impaired driving. It is provided by staff of the ARF Halton Region Centre, in cooperation with the Oakville Mayor's Committee.

Monitoring Issues in EAPs — June 17, 12:45pm–4:30pm, Hamilton Public Library. This workshop, sponsored by the ARF Hamilton Centre, concentrates on evaluating Employee Assistance Programs.

Play Memory — June 27, 7:30pm, Jane Mallett Theatre, Toronto. The ARF West Central Metro Centre and Theatre Plus present *Play Memory*, a work by Canadian playwright Joanna Glass depicting a man's alcoholism and its effect on his family. The evening is a benefit for the Toronto Addiction Awareness Week Committee. For information call Mary Pakula, (416) 595-6090.

NEXT ISSUE SEPTEMBER

USE THIS VALUABLE AID WHEN MAKING REFERRALS

Just Off the Press!

This comprehensive directory describes more than 350 agencies and services providing treatment for alcohol- and drug-dependent clients in Ontario. Twenty-four new agencies have been contacted and included in this 1987 edition, and the material on previously-listed agencies has been revised and updated.

The listings include not only addiction-specific resources, but also those of the general health, social, and corrective services which have significant interaction with substance-abusing clients.

Each entry lists full particulars of the facility—number of beds, intake policies, area served, description of program, waiting period, cost, average length of stay, and other pertinent information.

The entries are organized by geographical region, and are also cross-indexed by treatment type, by client type, and alphabetically.

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Spotlight on drugs

VIENNA — Approximately 2,500 delegates from around the world will gather here later this month for the United Nations International Conference on Drug Abuse and Illicit Trafficking (ICDAIT).

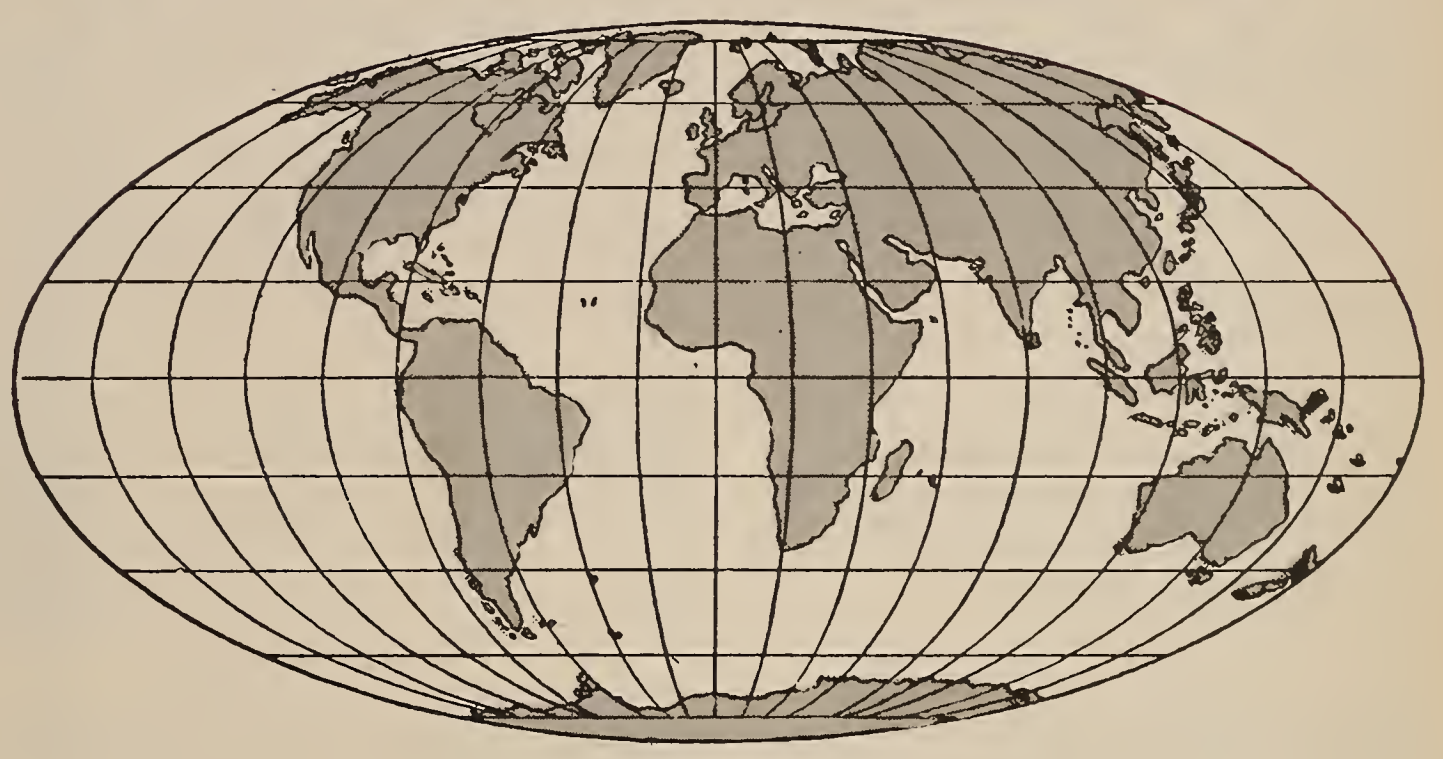
And, a report issued here by another UN agency sets the scene for what the ministerial-level delegates are going to discuss.

The report, by the International Narcotics Control Board (INCB), analyzes the drug-control situation worldwide and apprises governments of the results.

*The aim — this year, as every year — is to keep governments aware of existing and potential situations "which may endanger the objectives of the Conventions — the (1961) Single Convention on Narcotic Drugs and the (1971) Convention on Psychotropic Substances (***The Journal***, June, 1986) — drawing their attention to weaknesses in national control and treaty compliance.*

The 1986 report states: "Over the past two decades, the abuse of drugs, both natural and synthetic, has progressively spread, now affects virtually all countries, and menaces all segments of society . . . . The fashion in one abuser population inevitably attracts other such populations, within countries and across national borders."

Each nation must be alert to problems other countries are facing; therefore, **The Journal** *presents excerpts from the 1986 INCB report, highlighting major problems in various geographic areas.*



Near and Middle East

The large quantities of opium and heroin seized, both within the region and abroad, indicate the existence of extensive areas of illicit poppy cultivation and of substantial heroin manufacturing capacity. Cannabis is frequently seized and in large amounts. Traditionally, opium is abused in the region; and in recent years, the availability of locally manufactured heroin has led to widespread and escalating abuse of this drug too. Psychotropic substances are also abused, in particular methaqualone (eg, Tualone) and fenethylline (an amphetamine-based stimulant).

In **Afghanistan**, opium and cannabis are abused; seizures suggest heroin and methaqualone are also abused. Opium and cannabis seizures doubled in 1985 over 1984, and heroin seizures rose tenfold. The government is taking steps to develop prevention, treatment, and rehabilitation programs; legislation being enacted provides severe penalties for trafficking.

Large seizures of opiates continue to be made in **Iran**, primarily at the eastern borders. Nationals from Afghanistan, Pakistan, and India have been apprehended as traffickers. Enforcement has resulted in a decrease in purity of heroin at the street-level by some 50% and price increases between 20% and 30%. Under Iranian law, penalties for trafficking are as severe as for narcotic offences.

In Iran, drug abuse, especially opiate abuse, remains serious. Small-scale diversion — particularly of barbiturates — occurs from pharmacies. Rehabilitation facilities are available, and the government is improving coordination of various agencies involved in drug control.

Illicit opium production in **Pakistan** nearly tripled to 120 tons in 1985/86 from a record low of 45 tons during 1984/85. This reversal may be attributable, in part, to a high level of illicit demand for opiates within Pakistan and beyond. Mobile illicit heroin laboratories, using opium produced on both sides of the Afghan/Pakistan border, have been discovered — and dismantled — in tribal areas. Enforcement meant the doubling of heroin seizures between 1984 and 1985, to almost five tons; seizures of cannabis also doubled.

Turkey continues to successfully enforce its ban against opium production. The government's aerial and ground surveillance in 67 provinces showed no diversions from poppy cultivation licensed for the production of poppy straw and seeds. Situated as it is between Asia and Europe, Turkey is the site of transit trafficking in heroin and cannabis; the government is strengthening its capability to guard its sea coasts since drugs are trafficked out mainly by sea.

Authorities in the **eastern Arabian Penninsula states** are concerned about drug abuse: cannabis is widely abused, as are opiates — to a lesser extent. Large amounts of methaqualone are seized and abused in most countries in the subregion, and counteraction is being taken.

South Asia

India, which lies between major sources of illicit drugs, is a transit country for illicit heroin originating in parts of the Near and Middle East and Southeast Asia. Acetic anhydride orginating in India is smuggled to neighboring countries for use in the manufacture of heroin, some of which is trafficked back to and through India. Seizure data suggest opium is also illicitly trafficked internally and that a portion of the drug is diverted from licensed growing areas.

In 1984, the Indian government prohibited the manufacture, import, and sale of methaqualone. The drug, illicitly manufactured, has remained available within India and abroad, mainly in southern African nations. Large seizures continued to occur at exit points during 1985 and 1986.

Major urban centres, particularly Bombay and New Delhi, have had a steep rise in heroin abuse. A survey is being conducted in nine large cities to identify the extent of such abuse.

In **Sri Lanka**, heroin-related offences increased almost tenfold between 1984 and 1985. Nationals, initially recruited as couriers for opiates produced in the Near and Middle East, subsequently organized trafficking groups in Western Europe and established links with international criminal networks.

Large-scale cannabis trafficking continues in **Nepal**; drug abuse, especially of heroin, is reported to be spreading. Nationals are increasingly involved in international heroin trafficking, and increased penalties for trafficking are being legislated.

East and Southeast Asia

Extensive eradication of illicit poppy cultivation during 1985/86, both in **Burma** and **Thailand**, reduced the production of opiates in this region. Large seizures, in Thailand and **Hong Kong**, further diminished opiate supplies. Some mobile heroin labs along the Thai/Burmese border were dismantled, and traffickers shifted their operations elsewhere.

Heroin abuse in some parts of the region appears to have stabilized as countries reinforce preventive education, rehabilitation, and law enforcement. Cannabis and psychotropics are also abused.

Burma continues to eradicate illicit poppy crops. During 1985/86, more than 13,000 hectares of poppy were destroyed through aerial spraying and manual destruction. The area eradicated was 50% greater than the previous year. Acetic anhydride continued to be smuggled into Burma; strict controls by Thai authorities created a scareity of the chemical in the border area where manufacture takes place. Most of this heroin enters international illicit traffic via Thailand, although some amounts leave via India or are shipped via the Andaman sea.

Large-scale cannabis cultivation was detected along the southeast border of Burma; 65 tons were destroyed. Heroin abuse remains serious within the country; legislation has been amended to provide more severe penalties for abusers who fail to register for treatment. Abuse of methaqualone is believed to have inereased.

In Thailand, abuse of opiates, cannabis, and psychotropic substances remains high. More than 400 opium dens are believed to exist in Bangkok, and a long-term plan is being developed by agencies concerned and the city to eliminate these.

Opiates continue to be smuggled by trawler into Hong Kong from Thailand. Large seizures of heroin caused temporary price increases, but traffickers replenished stocks quickly. Despite extensive enforcement work, Hong Kong remains a trans-shipment point; cannabis originating in the Phillipines enters the territory in bulk-container cargoes, and lesser amounts are trafficked from Thailand, India, and Nepal.

Heroin abuse appears to have stabilized. Abuse of cannabis and psychotropic substances, mainly methaqualone, may be increasing but are still not significant.

In **Malaysia**, there has been a decline in the number of new heroin addicts, attributable to government action against trafficking, comprehensive rehabilitation programs, and after-care support. Opiates continue to enter the country from Thailand and Burma, and there have been smuggling attempts of these drugs from India and Pakistan. Nevertheless, there has been a heroin shortage — indicated by high prices, lower drug purity, and substitution of other psychotropics.

Oceania

Heroin and eannabis continue to be smuggled into **Australia**, mainly from Southeast Asia; attempts are also made to traffic heroin and cannabis resin from Southwest Asia. Illegally produced amphetamines are widely available; in 1985, three amphetamine and two methamphetamine labs were destroyed, and early in 1986, two more were dismantled. Cocaine is also being abused.

Because of its geographic location, there is limited availability of illicit drugs in **New Zealand**. Some heroin is trafficked via Australia, and illicit, local manufacture of morphine and heroin from codeine preparations continues. There were 18 such cases in the first six months of 1986; as a result, measures have been taken to reduce the number of tablets per package and to require special authorization for purchasing more than two packages.

Europe

In general, drug abuse does not constitute a serious public health problem. In some countries though, there is growing concern that narcotic plant cultivation leads to local diversion. Psychotropic drug use, in combination with alcohol, has also been noted in some countries.

In **Poland**, abuse of a locally prepared decoction containing alkaloids obtained from poppy capsules, clandestinely harvested from licit cultivation, is of concern. In **Czechoslovakia**, there have been sporadic cases of psychotropic drug abuse, often in combination with alcohol. Transit trafficking of heroin from India destined for Western Europe has led authorities to increase enforcement.

In the **Soviet Union**, authorities are increasingly concerned about drug abuse. Drugs are obtained primarily from eannabis grown for industrial purposes or growing wild. Drug thefts from medical or paramedical institutions are increasing.

Western Europe

There has been a stabilization — and even a decrease in some cases — of drug-related deaths. The average age of victims is also reported to be increasing in some countries, as is the age of drug-dependent people. In several countries, heroin abuse remains high; in others, it is stabilizing or decreasing. Coeaine abuse is widespread and increasing in some countries.

Heroin is still widely available, with 1985 seizures above 1984 seizures. The largest quantities were seized in the Unit-

(Continued on p10)

Spotlight on drugs

(from page 9)
ed Kingdom, the Netherlands, and France. But, both the number of people involved and the number of seizures have decreased.

Trafficking may be better organized; larger quantities are being smuggled by air and sea. More than 50% of heroin seized came from the Near and Middle East and South Asia; 18% came from Southeast Asia.

Cocaine continues to be widely trafficked and abused in several countries. Quantities, number of seizures, and number of people caught all declined in 1984 and 1985, but surged in 1986, particularly in the UK, France, and the Federal Republic of Germany (West Germany). Cocaine traffic through Spain continues, and law enforcement officials believe bulk quantities are coming into Europe through seaports.

There are also increased quantities of cannabis seized, up 450% over seizures of 1975. Most cannabis originates abroad, but domestic cultivation is increasing.

Abuse of central nervous system stimulants, primarily amphetamines, continues in the UK and Scandinavia; such abuse is up sharply in West Germany. In most cases, the drug is manufactured clandestinely, usually in the Netherlands and West Germany.

North America

Canada

Drug abuse and illicit trafficking remain serious; cannabis and its derivatives are most commonly abused. Most originates abroad although domestic production is increasing. Cocaine is plentiful and widely abused, particularly in large cities; crack is expected to appear. There are ample quantities of high-quality heroin available illicitly, mostly from Southeast Asia but also from Mexico.

There is diversion from licit opiate and some benzodiazepine supplies, especially in the cities, and clandestine manufacture of psychotropics is of concern. Amphetamines and LSD are trafficked from the United States.

Mexico

Cannabis remains the most widely abused drug; heroin is consumed mostly along the northern frontiers. Sporadic cases of cocaine and coca paste abuse have been detected, and organic solvent abuse continues to be a serious problem.

United States

Illicit consumption of various drugs, often in combination, remains a major public health problem. Cannabis continues as the most widely abused drug although surveys show decreased use by young people. Heroin abuse has stabilized; other dangerous drugs — methamphetamines, PCP, and fentanyl analogues — are abused. Cocaine is the drug causing most concern; it is estimated that four to five million people use it regularly, and crack is the form used more frequently.

In 1986, domestic cannabis eradication was carried out in all 50 states, both manually and by aerial spraying. US cocaine originates in South America, heroin in Mexico and Southwest and Southeast Asia. Synthetic narcotics and psychotropics are produced clandestinely in the US. The volume of trafficking is high.

Caribbean, Central and South America

South America

Enormous areas of coca-bush cultivation continue in Bolivia and Peru, the two major world producers, and new areas of illicit cultivation emerge in other areas of the region. The expansion of cultivation, along with ready availability of specific chemicals, has led to a significant increase in illicit cocaine production and traffic.

However, several countries are working on coca bush and cannabis eradication; drug control legislation has been strengthened, and emphasis has been placed on demand reduction campaigns. Regional cooperation has expanded.

Legitimate requirements for cocaine worldwide are minimal and steadily decreasing, and it's important licit suppliers — Peru and, to a lesser extent, Bolivia — license and effectively control production.

Despite government enforcement efforts, coca cultivation increased in Peru in 1985 and early 1986. There is a tendency to move processing facilities closer to coca cultivation; this has led to increased coca paste and cocaine availability locally.

In August, 1986, Peruvian authorities destroyed 14 airstrips and four large cocaine-processing labs in the northern jungles.

Illicit drug trafficking is gradually increasing in Brazil and is likely to expand further because of the country's extensive borders with Colombia, Peru, Bolivia, and Paraguay and because Brazil's large, unexplored regions offer traffickers an enormous area for illicit cultivation, manufacture, and trafficking.

Brazil is the only major South American supplier of specific chemicals, mainly acetone and ethyl ether, and is the entry point for US and European chemicals.

In Colombia, extensive areas of illicit cannabis cultivation have been eradicated by special army and police units. Several tons of cocaine have been destroyed, many cocaine refineries dismantled, and chemicals seized. New Colombian drug-control statutes broaden the prerogative of the National Drug Control Council and increase penalities for drug offences.

Ecuador has been mainly a transit country for Peruvian and Bolivian coca derivatives: however, extensive areas of illicit cultivation have been discovered and vigorous counteraction undertaken. Coca paste, cocaine, and cannabis are abused and education programs are underway.

Central America

Illicit cannabis cultivation occurs in most countries, as does transit traffic in cocaine and cannabis. Eradication is underway in Belize, where growing violence in northern districts appears to be drug-related.

Panama's location attracts traffickers who use it as a transit point for cannabis and cocaine from South America and for laundering trafficking-related monies.

Caribbean

Hundreds of islands, vast areas of surrounding water, and many illicit landing strips provide ready facilities for international smuggling. Strategic location and existing banking arrangements which facilitate money-laundering make some Caribbean countries favored choices for traffickers. Staggering profits from criminal trafficking foster corruption and even destabilize political organization.

In Jamaica, a significant decrease in cannabis seizures is attributed to eradication. Tighter security at airports has led traffickers to use seaports for distribution. Growing amounts of drugs hidden in shipments of other products is threatening Jamaica's licit exports. A lack of rehabilitation facilities causes concern.

Africa

Cannabis is abused throughout the continent and is produced in many countries. Large quantities are trafficked abroad, mainly to Western Europe, primarily from Morocco, but increasingly from Ghana and Nigeria.

Heroin, until recently virtually unknown in Africa, is now abused in Mauritius and Nigeria, which serve as transit points for Asian heroin intended for Western Europe and North America. Other transit countries like Côte D'Ivoire and Ghana are at risk of becoming centres of abuse.

Cocaine is appearing in Côte d'Ivoire, Ghana, and Nigeria, suggesting traffickers are trying to establish smuggling routes from South America through Africa to other regions. Cocaine abuse has begun in some countries.

Trafficking in psychotropic substances is substantial and increasing, the abuse problem is becoming more serious. Amphetamines and secobarbital preparations are widely available in West Africa and, to a lesser extent, in Central Africa. Methaqualone trafficking is substantial in eastern and southern Africa.

A growing number of countries — Botswana, Côte d'Ivoire, Malawi, Nigeria, and Swaziland — are strengthening drug control legislation.

HOWELL

Neanderthals we have known

Anthropologist Solomon Katz of the University of Pennsylvania says it was the discovery of beer and its mildly intoxicating properties that prompted paleolithic hunter-gatherers to give up the nomadic life and turn to the cultivation of grain crops.

He claims that approximately 10,000 years ago, wandering hunters in the Near East discovered that wild barley left to soak in preparation for making gruel could develop into an intoxicating beverage. The hunter-gatherers liked the effects of this beverage so much they abandoned their peripatetic lifestyle and took up grain farming to assure themselves adequate supplies of barley. Eventually, stable agricultural societies gave rise to towns, cities, and civilization as we know it.

* * *

A drunken sophmore crashes into the monthly meeting of the Shirley McLaine Astral Travel Society

FORT LAUDERDALE, Florida — March break, 1987: Matt Canister, a drunken sophomore from Penn State, staggers down a hotel corridor, lurches through what he thinks is a washroom door, and crashes into the monthly meeting of the Fort Lauderdale Shirley MacLaine Astral Travel Society by mistake. In the confusion that follows, Matt Canister is inadvertently bumped back in time 9,999 years. He awakes to find himself in a Near Easternish kind of place, in the company of a man called Lok.

Matt: "Hey, far out. Toooo much! Like I mean *REALLY* back to the future! Eat your heart out, Michael J. Fox . . . . So, your name's Lok, huh? Put 'er there, Lok. No, no, there. There! Hey, be cool man; I'm not trying to grab you. It's just a handshake, see, a friendly handshake . . . .

"So tell me, Lok, you got anything to eat around here? I got a right powerful appetite. No pizza, no burgers? Hey man, this really is the dawn of civilization! What about that slop in the pot? Yeah, that runny-looking porridge there, the stuff you were stirring when I dropped in.

"That's beer you say? Hey, love the stuff! I get tanked up on that and I turn into an animal . . . . Hey, don't look so frightened. Like I didn't mean it literal. It's just an expression, you know. It's a metaphor, you know what I mean? Well, I guess you don't, do you, Lok, not having had English 101 and all that . . .

"Say, this stuff's not half bad. I could run wild on this stuff easy . . . . Hey, did I say something? Like it's just an expression, you understand

"Come on man, sit down, mellow out, have a brew. No, not like that! Don't sip it, chug-a-lug it. Here, give me the gourd, I'll show you what I mean. Bottoms up. See, it's all a matter of breath control . . . . Okay, you try it. Come on, Lok, go for it! That's it, right down the old hatch, you've got it. You've got it, Lok. Now wait, don't go green on me! Don't puke-out on me, Lok. Hold it in and concentrate, and the feeling will go away.

"See. Didn't I tell you? Now pass the gourd over to me. Mmmm . . . hey, hey. All right! I mean *ALL RIGHT*! Yabadabadoo! Another round of this and I'm a Neanderthal . . . .

"Now what's the matter? Don't look so frightened. Hey, come on man, don't go way, it's just an expression. Lighten up. Let's see you knock back a whole gourd in one go. I'll even sing the chug-a-lug song as you do it. Okay, Lok baby, Okay! Siphon those suds my man, siphon those suds. Yahoo!

"Now, gimme the gourd. Let's get down, let's get primitive . . . . Hey, did I say something? What's the matter with you anyway? Why are you looking at me like that? Hey, I don't need this. I don't want any hassle. I don't know what I'm doing here anyway. All's I can remember, my buddy and me killed two sixes, some fox gave me her room number, and I was on my way to . . . . Hey, believe me, I don't understand *ANY* of this.

"So why don't you siddown, Lok. Take a load off. We might as well finish 'er off — there's only a little bit left. What the hell, lets go ape . . . . Now what's the matter? Hey, come back here. What's with the torch? Hey, Lok, come back here. It's just an expression, you know, I don't mean it literal. Hey, come on, do I look like an ape to you? I'm a college student for God's sake (belch).

"Hey, don't do that, Lok, don't do that. You burn that field and it's all over: no agriculture, no stable community, no Sumeria, no Thebes, no Athens, no Rome, no age of enlightenment, no industrial revolution, no University of Pennsylvania, no Fort Lauderdale.

"Hey, man, I'm serious. Honest. I took a course about that, you know, one of those freshman survey courses. Got a B grade too. Hey, come on man, take it easy with that torch or that whole flippin' field is going to go up in smoke, and you're going to be back stomping the savanna for a living.

"Hey, Lok, come on, lighten up, have a brewski, let's talk this thing out . . . ."

By Wayne Howell

INTERNATIONAL

Choices: sell your stereo to buy drugs?

Software gives hard lessons to teens contemplating drugs

By Karen Birchard

DUBLIN — SMACK, a new computer program now being used in some Irish schools to alert students to the dangers of experimenting with drugs, has been well received by both teachers and students.

SMACK takes students through stages and conditions encountered by drug abusers or potential drug users.

It starts off by asking students a number of personal questions and explains that a series of situations will arise on the screen as the program progresses. Those situations develop because of the choices or options students choose.

For example, students are placed at a party where they are offered drugs. If they accept the offer, the computer program takes them through possible situations which could result.

SMACK raises the problems of money, family relationships, and overdosing. The problem of money arises very early in the game.

If a student doesn't want to sell his stereo, SMACK asks if he would steal. How would he handle the anger of a parent? And perhaps more difficult, how would the student respond to a parent's grief?

As the projected drug abuse continues, the computer-user finishes in the hospital and/or involved with the police. Eventually, he is given the chance of rehabilitation and the hard choices that involves.

The software designers, Lendac Data here, say each situation is accurately portrayed. Chances of certain events happening — such as a drug overdose — reflect the actual chances of such an event as closely as possible.

"What happens to the user of the computer program is a direct result of the choices he makes as the program unfolds," said Rory Rushe of Lendac.

The computer users can see a summary of their progress as the program continues; this helps reinforce the impact of what's happening.

"SMACK will also help reinforce the attitudes of a person who is not inclined to try drugs," said Mr Rushe.

If students turn down the drug offers at the initial party, they go through various choices as the program progresses; they may save money through a part-time job, meet new friends, go on holidays, etc. The heroin abuser finds the opposite happening as she goes into a steady financial, social, moral, and physical decline.

The designers say the computer program was developed because of requests from teachers and the schools. It is available for use with the computers which are widely used in Irish and British schools; it will also be available for Apple users later this year.

Illegal alcohol contributes to Mexico's addictions woes

By Neale MacMillan

MEXICO CITY — Mexicans are consuming fewer traditional alcoholic beverages but more beer and distilled spirits, including a growing amount of illegally-produced alcohol.

There is also an increasing level of alcohol abuse among Mexican youth, held to be related to the country's economic crisis.

Figures from the Mexican Institute of Psychiatry (IMP), an agency of the federal Ministry of Health, show production of the traditional beverage *pulque* (the fermented juice of the maguey plant) fell to 234 million litres in 1983 from 312 million litres in 1972.

Meanwhile, beer production rose to 2,518 million litres in 1983 from 1,702 litres in 1972. Distilled spirit production went to 188,365 million litres in 1984 from 71,795 million litres in 1970.

La Jornada, a daily newspaper here, says brandies, rums, and table wines have become more popular because of large and expensive advertising campaigns by their producers. The shift away from the traditional *pulque* to beer and spirits occurred during a period when millions of Mexicans migrated from rural to urban areas.

The IMP notes another drinking trend, the growing use of 95% alcohol for mixing with other drinks or for direct intake. A Mexican household survey indicates consumption levels range from 1% to 6% of the general population, a use not limited to excessive drinkers or alcoholics.

Factors the IMP says contribute to increased use of 95% alcohol are:

- its cheapness (up to a sixth of the cost of controlled beverages);
- a decrease in the percentage of this alcohol which is denatured (made unfit for drinking by adulteration) to only 1.5% of that sold in 1985 from 46% of the production sold in 1974; and,
- lack of regulation controlling its sale, although the government has since introduced tighter controls.

Official figures based on the sale of controlled alcoholic beverages show per capita consumption of pure ethanol by Mexicans older than 15 years has fallen to 5.3 litres in 1984 from 6 litres in 1980.

However, these figures include neither uncontrolled production (annual production lower than 7,500 litres is not subject to government control) nor clandestine production and consumption.

Illegal production of alcoholic beverages is by its nature difficult to measure. Nonetheless, while sales of brand-name products have dropped in the past few years, illegal production has increased, says Victor M. Bernal Sahagun, a researcher with the National Autonomous University of Mexico's Institute of Economic Investigation.

The observation is based on reports by the World Health Organization and the Mexican Ministry of Health and on Mr Sahagun's own travels in different parts of the country. "We've seen that the situation is serious," he says.

Illegally-produced beverages range from 45-proof to 90-proof and include tequilas and sugar cane or corn-based *aguardientes* (types of rum or brandy), says Mr Sahagun.

They are being produced throughout Mexico in rural areas, small villages, and urban centres. He places much of the blame for illegal production on Mexico's economic crisis, which began in the early 1980s.

"Because people are short of money, they produce these drinks."

He added that alcohol abuse — and a growing problem of drug dependency — is especially serious for young people in Mexico and is also related to Mexico's economic situation. Until 1984, there were 75,000 teenage alcohol abusers; today there are 120,000.

INSIDE OUT

A song to a real friend

It is time for me to celebrate you now, although you may never read this and I would not possess the power, ever, to tell you face to face the facts that follow.

But, I need to put it on the record, even if it is in anonymous fashion.

Yes, I have to express my song of gratitude this way, because you know — you, with your natural reticence and shy discretion and sense of propriety — that the most powerful emotions people have for each other can never be spoken of with any clarity. Or without inevitably resorting to all the used-up, cigar-butt cliches about love; or in full sentences built on a lockstep logic. Or with the hammering rhythms of a great actor proudly riding a Shakespearean speech, like a wizard of a jockey.

No, the deepest things we feel belong, often, in the realm of an absolute silence, in a land beyond all words, in the most buried places of the secret heart.

Still, I have to try to tell you how I see you because, frankly, you are a miracle to me, an unending gift I never expected, did not know existed, could not have imagined on the wildest bender I ever had.

For that crippled part of me that is alcoholic, you represented, when the deadly liquid fog began slowly to lift from my life — and you still represent — a brand new constant, a lodestar, a fixed entity that only now I'm starting to see for what it's really worth.

I never expected to have a friend like you again, just after I left the clinic. I was too wounded and full of desperation; a cancer of hopelessness had wormed its way inside. I felt I had to be a 'good boy,' not take chances, learn my lesson, not make waves anymore, with my head down and my dreams in check.

Yes, I had friends, it is true — fine friends, friends who had gone to the mat for me, friends from my addicted years. And, I loved them, love them now even more in some ways.

For that crippled part of me that is alcoholic, you represented a brand new constant, a lodestar

But, wrongly, I guess, there were confusing and startling things I was feeling in my new sobriety I just couldn't talk about to them. I felt, through my still distorted lenses, that I would always be mired in our collective past, stuck there fast like a butterfly on a spot of glue, still the same old me to them, relatively speaking, but with the addition now of recovering alcoholic on my personal scorecard.

But, I wanted to lift off again; oh, how I wanted to live. I wanted to make a few dramatic changes, away from the glare of concerned eyes that stared at me now with their old ways of seeing.

How I longed for a new connection, freed from the past. How I wished to breathe a new kind of air that would fit the expansive environment I was seeking, that I knew was there for one who had been presented with another chance to see how delicious life can be.

It was, in a strange way, as if, in order to make those old, friendly eyes proud of me again, I had to pyschologically remove myself from them, to stealthily take steps I hoped would finally root me in a reality from which I could grow after so many years of standing still and then making one too many moves backwards.

And then, you showed up, danced in daintily, as it were, and I wasn't prepared for you at all. I resisted you at first; I fought your easy goodness, your quiet optimism, your courage, your shining normalcy. We were so different, in almost every area, we used to laugh at it. And yet, somehow we both knew that if we kept trying to break on through we would have — if we were brave and kind to each other — a magnificent friendship.

So, you guided me along, you pushed me into new areas; you made me expand, and you did it gently. For the first time in a long time, I surrendered my pride and I listened to somebody else. I learned to trust you totally, and it was like finding a home.

You never let me get off the hook when I was evasive, or cowardly, or cynical, or claustrophobic about the world. You never used my disease for any reasons as a weapon; in fact, we rarely talked about it.

You always included me in your astoundingly busy life and you kept me so active I felt dizzy sometimes. You showed me there were aspects about me that were worth cherishing, worth fighting for.

You have never lost faith in me and you dismissed my second-best efforts. Sometimes, I wondered why you cared so much, what could be your possible motives for doing so much for me. And sometimes, knowing by your actions exactly who you were, I fell to crying.

You took a very shaky man and made him stand upright, and I doubt you are aware of what that has meant to me. You restored me and you do not know it because you weren't trying to do anything special.

You were just you. You showed me that we simply cannot live unless we have a little honor in our lives, and how I want to make you proud of me for the rest of our lives.

Gifts on gifts you have granted me, my sweet comrade, away from all the eyes, in our secret garden of friendship, and all I ask is this mercy: let me, just once before I die, do the same for someone else, let me try to heal somebody who is stumbling, as I am in my addiction, with this most potent but infinitely precious prescription of yours, my beloved friend.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

COMMENT

GILBERT

Replying to critics

The editor didn't want me to reply to critics of my January and February columns on tobacco advertising. I persisted. The three responses, published in February (Lynn McDonald) and April (Kenneth Warner and David Sweanor), went beyond fair comment; they were insulting, sometimes libellous, attacks on my intellectual integrity. Not replying, I thought, could be seen as acceptance of the criticisms and agreement that **The Journal** publishes inferior material.

The three letters were remarkable for their venom (see letters, p6):

"Dr Gilbert's column is a misguided and arrogant attack. . . . Some of [his] arguments are so inane as to insult his readers. . . . [He] is offensive . . ." (McDonald).

". . . The extraordinarily misinformed and misleading nature of his comments. . . . Dr Gilbert's knowledge of health hazards and his perspective on comparative ethics are nothing short of astonishing. His reliance on, and apparent belief in, tobacco industry sources suggests a rather extraordinary naiveté or bias" (Warner).

". . . Our most serious concern is that these shoddily researched, unprofessional columns appeared in a reputable addiction newspaper" (Sweanor).

Lynn McDonald did at least admit that I might be right, that my criticisms of the arguments of advocates of a tobacco ban might be correct. She objected to nothing more than the expression of a view contrary to hers, and to a perceived misquote of Voltaire. I did not quote Voltaire. Her several paragraphs of correction on this point were puzzling.

Kenneth Warner and David Sweanor also misread and misrepresented what I wrote. Both said I claimed that automobile accidents kill more people than smoking. I did not. I wrote that automobile *use* may cause more deaths than tobacco use, pollution being the main factor, and adduced data published in the prestigious journal, *Nature*.

In my first column, criticism of Professor Warner's arguments before a United States Congress subcommittee began with consideration of Norway. I wrote that the decline in cigarette use in that country began *before* the 1975 advertising ban, not after the ban as he told the committee. Arguments such as Dr Warner's that the ban caused the decline are false.

Banning opinion, however banal, uncomfortable, or dangerous, is the first step toward book burning

Dr Warner's response was not to produce evidence but to claim that I had used tobacco industry data. My information came from Norway's Directorate of Customs and Excise and Central Bureau of Statistics. Annual sales of smoking tobacco and cigarettes in Norway increased at the fairly constant rate of 1.7% a year from 1949 until 1971 and thereafter declined by an average of about 0.2% a year. The advertising ban was not introduced until 1975. These data have also been published in *Nature*.

These sources are not known to be stooges of the tobacco industry. Nor is Benjamin Singer of the University of Western Ontario, whose 1986 book, *Advertising and Society*, was my source as to which products are the most advertised in Canada. Mr Sweanor claimed that my information on this point came from the tobacco industry.

Mr Sweanor also repeated the statement by two of the deputants before the Congressional subcommittee that tobacco is the most advertised product in the US. He said I was "flat-out wrong" to contradict this, an assertion reproduced in the headline to his letter.

The *Top 200 Brands Directory* for 1985 (the latest issue) says the most advertised categories were: restaurants, hotel dining, and nightclubs; domestic passenger cars; and, cigarettes. In newspapers, the main medium for cigarette advertising, even airlines were ahead of cigarettes in both 1984 and 1985.

Dr Warner's jibe about my astonishing comparative ethics followed his assertion that automobiles provide substantial social benefits that outweigh their social costs, whereas cigarettes do not. This is a moot point in itself, not obviously relevant to what it purported to counter, namely my argument that advertising of a product should not be banned simply because the product causes harm.

I could go on, and on, and on — rebutting every point, for every allegation made by these critics is wrong, or a matter of opinion.

The critical letters, particularly Prof Warner's, who claims academic credentials, are further indications that ordinary professional standards have been compromised in pursuit of a legitimate end, reducing tobacco use in order to improve health.

The federal government has now been taken in by the arguments that a ban on advertising will reduce tobacco use. It has announced a ban, effective January, 1989 (see clippings at left; story, p2).

Correct information is the civilized and democratic answer to misinformation put out by the tobacco companies or by anyone else. Banning opinion, however banal, uncomfortable, or dangerous the opinion might be, is the first step toward book-burning.

By Richard Gilbert

Tobacco ad ban carries penalties of $1[illegible]

Ban on tobacco threatens tennis, golf ev[illegible]

By Ken McKee Toronto Star

Several major sports competi[illegible] perhaps more s[illegible] tobacco companies drop out "is the last companies (in Canada) that can price tag of competitions of Dick Gramm dire[illegible] tournaments fo[illegible] Associat[illegible]

Ottawa set to widen smoking curbs and ban all advertising of tobacco

Continued from page A1

smoking lobby, forced a long delay in the comprehensive government policy

It was probably a bill proposed by an opposition MP that

However, the anti-smoking movement will undoubtedly be pressed by strong indi[illegible] calling that the government intends to eventually forbid smoking in all govern[illegible] and federally regulated workplaces ment, no exceptions.

to put a health warning on all c[illegible] packages and to implement a [illegible] code covering newspaper, billboard and poster advertising

Recently, several newspapers have voluntarily refused to accept any further tobacco advertising. The Toronto Star stopped carrying any on March 31

Ironically, the [illegible] on the heels of the 3[illegible]

Continued from page A1

bulture department's announce[illegible] ment of a $30-million program to help tobacco farmers switch to [illegible] other [illegible]

Jake Epp, Labor Minister Pierre Cadieux and Treasury Board President Robert de [illegible]

sions had also [illegible] on

Park $745 million in taxes. The Ester reports [illegible] A pack of 25 cigarette[illegible] price but manufactur[illegible]

Last year the figure [illegible] a 15 per [illegible]

Ottawa to ban all tobacco ads, enforce non-smoking laws

[illegible]gencies fear ban's 'devastating' effects

Cigarette war draws outrage in tobacco belt

SIMCOE, Ont[illegible] — Mayors in [illegible] Ontario's tobacco belt are [illegible] federal govern[illegible]

Ad ban: Canadian Health Minister Jake Epp makes his move

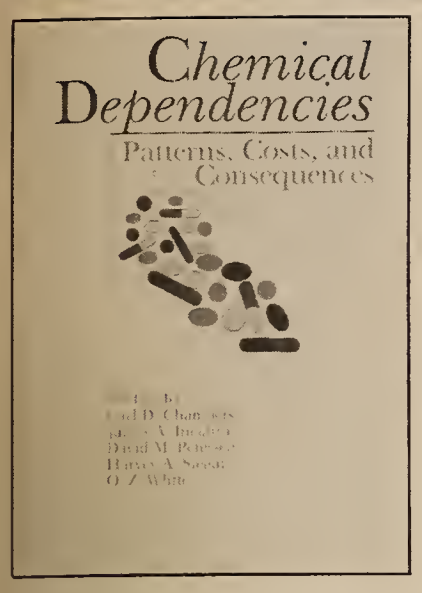
Coming up in THE JOURNAL

- *The National Drug Strategy — background and highlights*
- *NECAD*
- *CAF Atlantic Conference*
- *Alcohol and the Family*

REVIEWS

New Books

by Margy Chan*



Chemical Dependencies provides the layperson and beginning student with generalized, non-technical information about drugs and their effects. It gives an in-depth description and analysis of drug abuse in specific populations (eg, adolescents, minority groups, the elderly, rural families) and discusses health consequences of use, misuse, and poly-drug use.

The relationship between crime and drugs is examined, including youth delinquency and street crime and criminal involvement of minority-group addicts and older men.

This is an excellent overview of the drug-abuse problem in the United States. The epidemiological data and quality of the contributed papers represent a significant addition to knowledge and understanding of the problem.

Ohio University Press, Athens, Ohio. 1987. 581 p. $44.95 (cloth). ISBN 0-8214-0846-1; $24.95 (paper) ISBN 0-8214-0847-X.

Directory of Alcohol and Drug Treatment Resources in Ontario, 1987

. . . edited by Donna Heughan

This is an annual update of an Ontario-wide survey from the Addiction Research Foundation's community services division. Some listings have been revised, and 24 new agencies are included. Program descriptions are grouped geographically: for easy retrieval, they are again listed alphabetically and indexed by treatment type.

The directory will assist addiction workers and other community professionals assess which treatment programs suit their clients with alcohol and other drug problems. A treatment and rehabilitation guide for parents and others has been added. Agency criteria are provided in question and answer format.

Addiction Research Foundation, Toronto, Canada. 1987. 503 p. $20. ISBN 0-88868-148-8.

Drugs and Drug Abuse: A Reference Text, Second Edition

. . . revised by Michael Jacobs and Kevin O'B. Fehr.

The second edition of this valuable reference text updates many of its major drug articles. New entries have been incorporated to reflect recent and important trends of drug use: the chapter on cocaine has been enlarged; information on designer drugs, MDMA, and naltrexone has been added.

New subjects of special note include discussions of endorphins, definitions of drug abuse, and adverse effects of various drugs on driving. A number of new terms have also been added to the glossaries, and the trade-names list for Canadian and United States products has been updated.

Addiction Research Foundation, Toronto, Canada. 1987. 639 p. $29. ISBN 0-88868-139-9.

Recent Developments in Alcoholism Volume 5

. . . edited by Marc Galanter; associate editors, Henri Begleiter, Richard Deitrich, Donald Goodwin, Edward Gottheil, Alfonso Paredes, Marcus Rothschild, and David Van Thiel

This series offers official publications of the American Medical Society on Alcoholism and Other Drug Dependencies, the Research Society on Alcoholism, and the National Council on Alcoholism in the United States. Each volume, an overview of recent developments in the field, is the work of a panel of associate editors, invited editors, and authors, all prominent scholars and researchers in a wide range of disciplines, committed to the advancement of knowledge of the etiology, treatment, and prevention of alcoholism and alcohol-related problems.

The first section of this fifth volume focuses on the effect of alcohol on memory, the second on the relationship between alcohol treatment and society. The third section centres on the effects of ethanol on ion channels, and the final section deals with hazardous and early problem drinking.

Plenum Press, New York, NY, 1987. 457 p. $65. ISBN 0-306-42427-4.

Books received

My First Ninety Days — an Anonymous Addict. Quotidian Inc, Stroudsberg, Pennsylvania. Distributed by Thomas Perrin, Rutherford, New Jersey. 1986. 91 p. $4.75. ISBN 0-934381-09-2.

Co-dependence: Misunderstood — Mistreated — Anne Wilson Schaef. Harper & Row, San Francisco. 1986. 105 p. $7.95. ISBN 0-86683-486-9.

A Family Like Yours: Breaking the Patterns of Drug Abuse — James L. Sorensen and Guillermo Bernal. Harper & Row, San Francisco. 1987. 194 p. $15.95. ISBN 0-06-250820-2.

A Parent's Survival Guide: How to Cope When Your Kid is Using Drugs — Hamiet W. Hodgson. Harper & Row, San Francisco. 1986. $6.95. ISBN 0-06-255424-7.

** Margy Chan is manager of the Addiction Research Foundation's library, the leading library in the field worldwide. A graduate of the University of Hong Kong, she holds a master's in library science from the University of Toronto.*

ON-SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

All the Kids Do It

Number: 784.
Subject heading: Impaired driving; alcohol and youth.
Time: 28 min.
Synopsis: Buddy is trying out for the Olympic diving team; diving is important to him because he wants to be the best at something. On his 16th birthday, his father gives him a car and warns he must never drink and drive. A friend drops by, and Buddy takes him for a ride; his parents are angry when they discover he has been drinking and driving. Later, Buddy's friends come to a diving practice: they persuade him to have a few drinks. He dives so badly he realizes he could have killed himself. Buddy's friend drives home; they are chased by the police and caught. This time, Buddy's parents ground him. At a final practice before the Olympic trials, Buddy's coach says he'll probably make the team. On the way home, Buddy's car is sideswiped by an impaired driver; Buddy is badly injured and misses the Olympic trials.
General evaluation: Very good to excellent (5.5). This contemporary, well-produced film is an excellent teaching aid that would lead to good discussion about many aspects of impaired driving. Scott Baio is believable as the teen diver. General broadcast is recommended.
Recommended use: With a resource person, the film would benefit those 12 to 18 years of age.

Why Say No to Drugs

Number: 763.
Subject heading: Drugs and youth.
Time: 16 min.
Synopsis: Messages about drugs are all around us. Young people have to decide what they will do when offered any drug. The effects of cigarettes, alcohol, and marijuana are shown; techniques for saying no are illustrated. Young students explain what they think about using drugs; older students reinforce that it is acceptable to say no and that drug use is a personal decision.
General evaluation: Very good (5.2). This contemporary, well-produced film uses excellent visual effects. Role modelling of saying no is effectively portrayed. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit eight to 12 year olds.

Power Health

Number: 788.
Subject heading: Lifestyles.
Details: 23 min, video only.
Synopsis: The video says it's important to feel good mentally as well as physically. Although everyone has needs — to belong, for power, for freedom, and for fun — there are different ways to satisfy these needs: weak solutions and power solutions. Weak solutions like drug use, have negative side-effects; power solutions, like learning self-control and participating in many healthy activities, have no negative side-effects.
General evaluation: Fair (3.4). The video contains good information about healthy lifestyle alternatives. However, its pace is slow at the beginning, and the dissolve format is not well-executed.
Recommended use: With a resource person, the video could be used with young people 12 to 14 years of age.

The Junkyard

Number: 785.
Subject heading: Impaired driving.
Time: 22 min.
Synopsis: This film shows how four vehicles end up in the junkyard after drinking-driving accidents. Jimmy Joe, a truck driver, uses pills to stay awake; one Friday night, he drinks in addition to taking pills — his vehicle ends up in the junkyard. Tommy's car comes to rest in the junkyard after he drinks beer and smokes pot at his high school graduation party. Chuck does not feel drinking beer only can lead to a problem: his car is towed to the junkyard after he drives it into a lake. Liz takes tranquillizers to deal with work stress: after having a drink with a friend, she drives home and kills a young child — her car goes to the junkyard.
General evaulation: Fair (3.0). The film has a clear message, but seems oppressive and repetitious.
Recommended use: With a resource person, the film could be used with general audiences.

From Candy to Cocaine

Number: 776
Subject heading: Cocaine.
Time: 30 min.
Synopsis: Four teenagers, on a bare stage, introduce the topic of cocaine use, giving statistics and relating some of their experiences. Other teens talk about their use: at first, cocaine was "the greatest," and they would do anything to get it. Soon, however, their lives deteriorated and became unmanageable. Parents tell their stories. The teens recount difficulties in treatment. In spite of the difficulties, they say treatment now seems worthwhile.
General evaluation: Good to very good (4.9). This contemporary film covers most aspects of cocaine use, abuse, and treatment. It would stimulate discussion about the hazards of cocaine. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit parents and health professionals.

Not To Be Sniffed At

Number: 764.
Subject heading: Solvent abuse.
Time: 30 min.
Synopsis: In England, young adults, police, and a psychiatrist talk about their roles in the problem of solvent abuse. The users suggest there is no legal way to stop users. A self-help group has been set up.
General evaluation: Poor to fair (2.6). While this video is interesting, its focus on a specific subculture of British society means it has limited appeal to North American audiences. The methods and materials for solvent sniffing are too clearly illustrated.
Recommended use: None.

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Career Opportunities

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Duty to Treat *vs* Right to Consent: Striking the Balance — June 2, Toronto, Ontario. Information: Nancy Forbes, educational services dept, Queen Street Mental Health Centre, 1001 Queen St W, Toronto, ON M6J 1H4.

Work and Well-being 87 — June 12-14, Edmonton, Alberta. Information: Canadian Mental Health Association, #200, 12120 - 106 Ave, Edmonton, AB T5N 0Z2.

Canada Safety Council 19th Annual Conference — June 14-17, Toronto, Ontario. Information: Marie Juneau, director, national services, Canada Safety Council, 1765 St Laurent Blvd, Ottawa, ON K1G 3V4.

Summer School for Addiction Studies — July 6-24, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1

28th Annual Institute on Addiction Studies — July 12-17, Hamilton, Ontario. Information: Betty Collins, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

International Association of Forensic Sciences 11th Meeting — Aug 2-7, Vancouver, British Columbia. Information: International Association of Forensic Sciences, 801-750 Jervis St, Vancouver, BC V6E 2A9.

5th Annual Current Issues in Chemical Dependency Summer School — Aug 17-20. Winnipeg, Manitoba. Information: Noreen Kumlin, Rm 541, University Centre, University of Manitoba, Winnipeg, MB R3T 2N2.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

1987 Criminal Justice Congress — Sept 27-Oct 1, Toronto, Ontario. Information: Congress 87 organizing committee, 60 St Clair Ave E, Ste 600, Toronto, ON M4T 1N5.

Input 87, 7th Biennial Educational Symposium on Employee Assistance Programs in the Workplace: Networking and New Perspectives — Oct 25-28, Ottawa, Ontario. Information: Input 87, conference and seminar services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

United States

Children at Risk: Alcohol and the Elementary Student — June 18-20, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

36th Annual Session University of Utah School on Alcoholism and Other Drug Dependencies — June 21-26, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, UT 84110.

1987 Forum on Responsible Beverage Service — June 22-24, Portland, Maine. Information: 1987 Forum, Responsible Hospitality Institute, 11 Pearl St, Box 4080, Springfield, MA 01101-4080.

4th Annual Plaza House Conference, Treatment of Alcoholism and Cocaine Addiction: Individual and Family Approaches — July 11-12, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

16th Annual San Diego Summer School of Alcohol and Other Drug Studies — July 12-17, San Diego, California. Information: Alcohol and Other Drug Summer School, University of California, San Diego, X-001, La Jolla, CA 92093.

US Mexico Confernce on Alcohol-Related Issues — July 23-25, Los Angeles, California. Information: Beatriz Solis, conference coordinator, University of California, Los Angeles, Spanish Speaking Mental Health Research Center, Los Angeles, CA 90024.

New Jersey Summer School of Alcohol and Drug Studies — July 26-July 31, New Brunswick, New Jersey. Information: State University of New Jersey, Rutgers, education and training division, Center of Alcohol Studies, Smithers Hall, Piscataway, NJ 08854.

30th Annual Institute of Alcohol and Drug Studies — July 26-31, Austin, Texas. Information: Bill Britcher, Texas Commission on Alcohol and Drug Abuse, 1704 Guadalupe, TX 78701-1214.

10th Annual North Carolina School for Alcohol and Drug Studies — Aug 2-7, Wilmington, North Carolina. Information: Office of special programs, University of North Carolina Wilmington, 601 College Rd, Wilmington, NC 28403-3297.

American Hospital Association Annual Meeting — Aug 3-5, Philadelphia, Pennsylvania. Information: John A. McMahon, president, 840 N Lake Shore Dr, Chicago, Illinois.

North American Congress on Employee Assistance Programs — Aug 10-13, Seattle, Washington. Information: NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, Michigan 48084.

38th National Conference on Alcohol and Drug Problems — Sept 20-23, St Louis, Missouri. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St, #181, Washington, DC 20001.

National Association of Lesbian and Gay Alcoholism Professionals 2nd National Conference — Sept 24-27, Chicago, Illinois. Information: NALGAP, 1208 E State Blvd, Ft Wayne, Indiana 46805.

American Association for Automotive Medicine Annual Meeting — Sept 27-29, New Orleans, Louisiana. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Oct 3-7. Chicago, Illinois. Information: Thomas J. Delaney, executive director, ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Public Health Association Annual Meeting — Oct 18-22, New Orleans, Louisiana. Information: William McBeath, 1015 15th St NW, Washington, DC 20005.

Association for the Advancement of Behavior Therapy Annual Meeting — Nov 12-15, Boston, Massachusetts. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

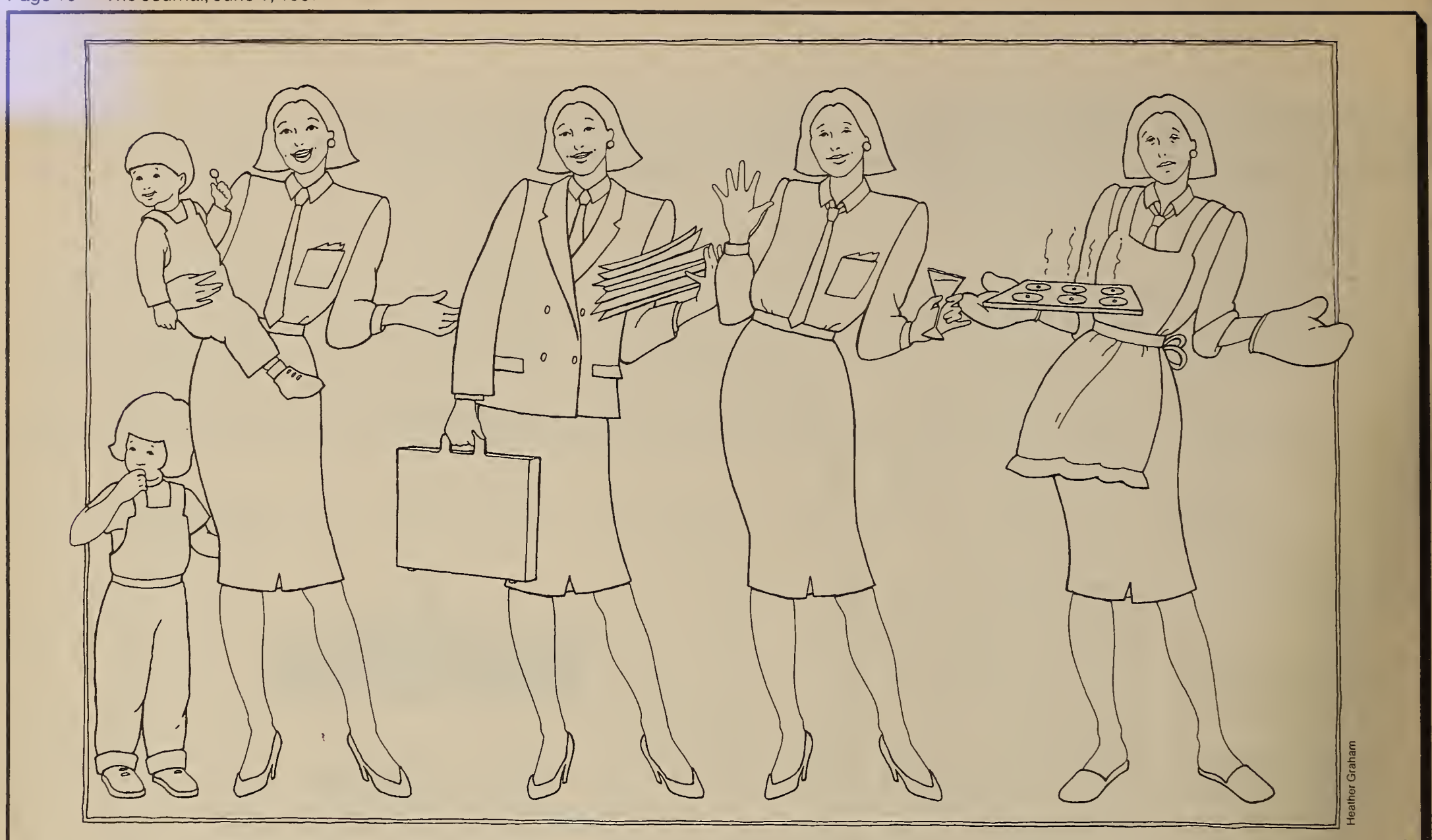
Abroad

Alcoholism and Drug Abuse, International Symposium — June 27-29, 1987, Rio De Janeiro, Brazil. Information: Continuing Education Abroad, 38760 Northwoods Dr, Wadsworth, Illinois 60083.

International Conference on Drug Policy Reform — July 13-17, London, England. Information: Drs Beyerstein and Alexander, dept of psychology, Simon Fraser University, Burnaby, British Columbia V5A 1S6, or Robert Fitton, conference coordinator, School of Justice, American University, Washington, DC 20016.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Secretariat, 6th World Conference on Smoking and Health, c/o Japan Convention Services Inc, Nippon Press Centre Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.



Heather Graham

Help wanted: superwoman and addictions

DENVER — Superwoman is developing a drinking problem, and the at-work resources are just not adequately available to help her cope.

That summarizes one of the major treatment problems facing those working with women and addictions in 1987, delegates at the 1st National Conference on Women's Issues here were told.

The conference was coordinated by the Alcohol and Drug Problems Association of North America (ADPA) Washington, D C. **Paul Szabo** *reports.*

Many professional women are developing chemical dependencies to help cope with the stress new roles bring, but traditional employee assistance programs (EAPs) are not designed for them.

Such programs were designed for men by men, in a time when women were mainly employed in lower-paying jobs and quit or were fired rather than be referred to such programs.

Now, many professional women are saying, "I am suddenly a very powerful, very influential person, and all this stress is driving me up the tree."

Patricia Ann Pape, president of Pape and Associates in Wheaton, Illinois, told the conference she refers to this as the 'superwoman' complex.

Jan Johnson, chairperson of the ADPA women's commission and director of planning and evaluation at the Hazelden Foundation, Center City, Minnesota, agrees.

Ms Johnson told The Journal: "I think the biggest problem is that women more and more are in managerial and executive-administrator types of positions in organizations across the country . . . and now, as chief executive officers, cannot be just suppressed or set aside.

"Because of (such) elevation in stature, it's more and more crucial that we address issues that (professional women) bring to treatment programs differently than we have historically for women who are homemakers and housewives . . . ."

Ms Johnson: "The superwoman complex (evolves) when you're working 9 am to 5 pm, and you've got to be superwoman — for your kids, in the community, and on the job. You're staying up until midnight sewing costumes and baking brownies; you don't want anything to happen, and you don't want your children to suffer simply because you've got a job.

"So, you're going to take all kinds of stimulants to stay awake and get all that done and downers so you can finally sleep and to get through the day. And, to cope with all the feelings of isolation and loss of self-esteem, 'Here comes the wine and the beer.' "

Ms Pape told the conference: "In the past, there were very clear rules about women's drinking: where, when, with whom, and how they could drink.

Right to compete

"Today, women are winning the right to compete with men in all areas of their lives including three-martini lunches and stopping off for drinks after work, and they're taking advantage of that."

Ms Johnson agreed this is especially true of younger women and will not change until Western culture ceases to be male-dominated.

"As long as there are men who are in key positions, who still have the power, women are unfortunately going to play those games and those rules — to drink like a man and think like a man . . . instead of hearing the message, 'It's okay to be a woman . . . and be in your own arena.' "

Ms Pape pointed out such women tend to be in the later stages of burnout and middle stages of dependency before they ask for help.

She and other speakers said inpatient treatment is often not an option for single-parent mothers because of the lack of child care facilities.

Sheila Blume, MD, said a recent survey of inpatient programs in the United States showed none offered concurrent child care for children of addicted women.

However, Ms Johnson said programs with child care are starting to become available. But, "if programs that provide child care for the kids are not more and more available, we're going to lose another real section of our population."

It is also important that children of addicted mothers receive counselling at the same time as their parents in order to understand what the problems are and to lessen the risk of becoming addicted themselves, she said.

While Ms Johnson suggested professional women constitute the major challenge to those in the treatment field today, she said the underlying problems they face are those that most women who develop some form of chemical dependency face.

"The issue is shame, the issue is guilt, the issue is self-esteem. But, the manifestations are what are so different."

She added that most EAPs were designed to help men return to their jobs. Because in the past women did not occupy positions as important as they do in many organizations today and were only in the workforce on a part-time basis, they tended to be fired or to quit rather than go into treatment.

And, Ms Pape added, even today many women tend to be underemployed, capable of doing their jobs "with their eyes closed," and therefore less likely to be referred to EAPs with performance-related problems.

Conference speakers stated repeatedly that male supervisors are often reluctant to refer female workers for treatment, tending rather to protect them or to justify their problems as being "emotional."

In fact, said Ms Johnson, women will access EAPs as readily, if not more readily, than men, if given the opportunity. And, new EAPs are being developed to help women workers specifically.

Other speakers, particularly two who work with American Telephone and Telegraph (AT & T) challenged the perception that EAPs are being underutilized by women. They presented statistics from a three-year study ending in 1986 showing that women in AT & T are making proportionately more use of the company EAP than men are and that this trend developed over the three-year study period.

But the difference, they agreed, is that women are not referred for problems linked directly with alcohol and other drug abuse as are men, but rather for emotional, marital, or family problems.

Not alone

Carolyn Major, a manager with AT & T, said some attempt is being made to increase the referrals of women with dependency problems even though these problems may not be as apparent in their job performance as those of men.

Utilization statistics from 1986 for the AT & T employee assistance program show men were more than three times as likely to be referred for problems associated with alcohol and other drugs.

Both Ms Major and Ms Johnson suggested peer groups in which women co-workers refer each other may be an effective way of getting more women into treatment as well as giving professional women the camaraderie they need.

Although their problems are highlighted, up and coming superwomen are not the only group of working women with problems related to addiction today.

Ms Pape said young working women and those re-entering the workforce also face difficulties that may lead them to turn to alcohol and other drugs.

THE BACK PAGE

Swallowed needles latest medical hazard for addicts

X-ray: needle imbedded in respiratory tree

By Paul Szabo

DENVER — Swallowed needles are a previously unreported medical hazard facing intravenous (IV) drug abusers.

A New York physician reported here on nine IV drug abusers who accidentally swallowed needles they were holding in their mouths while preparing to inject drugs.

Michael Nash, MD, chief resident in otolaryngology, New York Eye and Ear Infirmary, New York, said all of the patients recovered with no lingering symptoms. But, improper treatment of the condition could result in potentially serious injuries, he told the spring meeting of the American Academy of Otolaryngology, Head and Neck Surgery.

He said the nine cases, from three hospitals in the New York area, were the result of mueh the same set of circumstances.

Drug addicts prefer to use smaller needles to lessen pain and often hold the needles in their mouths — "much the same way that a tailor holds pins in his lips" — while drawing liquid up into the syringes with larger needles.

"What happens is they cough or something — one guy coughed, another sneezed, one guy's friend hit him in the back — to make them breathe in, and then the needles enter the respiratory tree."

In all cases, Dr Nash said, the person realized what had happened and immediately went to a hospital. Only one patient reported any pain resulting from the swallowed needle.

Dr Nash said the best way to remove the needle is to use a rigid bronchoscope to allow the surgeon to locate and extract the point of the needle from the lining of the airway.

Trying to make the patient vomit is potentially more harmful because the point could "scrape the whole airway on the way up."

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INSIDE

Canada missing IV link to AIDS . . .

By Kate Fournis

WASHINGTON — The problem of AIDS in Canadian intravenous (IV) drug users is a potential "ticking time bomb."

Less than 0.5% of Canada's 1,052 reported AIDS cases are among people with IV drug abuse as the only risk factor. But, that figure may not tell the whole story, says Cate Hankins, MD, a member of the National Advisory Committee on AIDS (NAC) and an epidemiology consultant in sexually transmitted diseases at Montreal General Hospital.

Canadian drug addicts have been largely ignored by AIDS researchers, but they have become a priority for NAC, she told **The Journal** at the 3rd International Conference on AIDS here.

In the United States, IV drug abusers infected with human immunodeficiency virus (HIV) account for most heterosexually- and perinatally-acquired cases of AIDS.

"We act like they don't exist," Dr Hankins said. "I would rather find out that they don't exist, that it's not a problem, than to assume that because we don't hear anything, there's nothing going on, especially with a five-year incubation period (from infection to full-blown AIDS).

"It could be a ticking time bomb, or it could be a fizzling firecracker. It depends completely on what you find.

Drug users – a ticking time bomb?

"But not asking the questions, playing the ostrich with your head in the sand, is insane."

Canadians have thought that HIV infection would never become a big problem in IV drug users here because needles and syringes are accessible.

But they are also freely available in Italy — where 30% to 70% of addicts are reported to be infected, Dr Hankins noted.

Data from Milan and other cities also show that sero-prevalence rates among IV drug users can shoot up dramatically in a short time, exploding from about 5% to 50% in just two or three years, she added.

The only data on HIV infection among Canadian drug users come from the first 18 months of voluntary testing in British Columbia. Of 345 addicts who asked to be tested, seven (2%) were positive. The rate was 4% for women (five of 128 tested), and 0.9% for men (two of 217).

Although those figures may be biased and may not represent a random sample of drug users, they do indicate that there is a higher percentage of addicts infected than is apparent from the reported AIDS cases, Dr Hankins said.

In addition to data on infection rates, information is needed on patterns of drug abuse and on the addicts themselves, she said. That information includes estimates of numbers of IV drug users, their needle-sharing practices, and just who they are.

"What is the group like? Is it like the US group, where the majority of the addicts appear to have started using heroin in the late 60s/early 70s and they're an older population, between 30 and 40? Or, are they like the European addicts, where most of them seem to be between 20 and 24 years, young addicts who've just started to use?

"It makes a lot of difference because there are people who say we are never going to be like the US, where 17% of our cases are IV drug abusers — that we don't have the kind of social system that generates that amount of IV drug abuse.

"There are other people who say it's just a matter of time, based on the fact that if our population, even if it is small, gets infected, and if homosexuals really do incorporate AIDS prevention messages and practice safe sex, proportions can change."

. . . 'Dramatic' rise in US death rates

By Harvey McConnell

WASHINGTON — Deaths among intravenous drug users from complications of the AIDS virus in the United States may be 100% higher than is currently recorded.

Don Des Jarlais, PhD, New York State Division of Substance Abuse Services, told the 3rd International Conference on AIDS here surveillance of AIDS cases may be dramatically underestimating the effects of HIV infection among IV drug users.

Work currently being carried on with the New York city department of health shows that from 1978 through 1986 there has been a dramatic increase in deaths, from a wide variety of sources, among IV drug users.

Dr Des Jarlais: "AIDS represents a substantial proportion of these deaths, but there are many other increases in (categories of) deaths at levels that have to be considered epidemic. For example, tubereulosis deaths among IV drug users have gone to 30 in 1986 from three in 1980; deaths from endocarditis have gone to 58 in 1986 from two in 1980; and, deaths from non-pneumocystic pneumonia have gone to 169 in 1986 from seven in 1980.

"Clearly, these represent epidemic increases in fatalities in what are not currently considered AIDS or HIV-related deaths."

He said risk factors range from between two- and seven-fold increases for drug users with HIV infection, compared to sero-negative drug users.

Dr Des Jarlais said there certainly is a possibility the local variations among people-at-risk in the endemic levels of other diseases may be influencing the outcome of HIV infection. It would be important to study other geographic areas and other sources of death among IV drug users.

He noted, for example, that there have been reports of increased cases of tuberculosis from a variety of geographic areas, including the US west coast, coincident with HIV infection.

"But, we must face the possibility that simple surveillance-definition AIDS may be capturing only one half of increased deaths among people infected with HIV and subject to a wide variety of other potentially fatal infections.

(See HIV, p2)

Heavy drinkers are warned — testosterone drop can last

By Betty Lou Lee

TORONTO — Just one night of heavy drinking ean lower a man's testosterone level by 50%.

It will return to normal within 24 hours without further drinking; but, with prolonged heavy eonsumption, the endocrine cells in the testes may lose their ability to reeover. The result is loss of sexual interest, low libido, and impotence.

"A transient drop in testosterone is of no signifieance," says David Van Thiel, MD, chief of gastroenterology, University of Pittsburgh School of Medieine, Pittsburgh, Pennsylvania.

"But, if you never stop your aleohol consumption, you never let the eells recover. Then even if you do stop, they ean't recover."

He estimates that "more than three drinks a day is getting into the danger zone, you're starting to test your ability to recover. It may take five to 10 years for it to be permanent."

At a press eonferenee at the

(See Alcohol, p2)

NEWS

Briefly . . .

Brand loyalty

WASHINGTON — Crack is now being sold in tablet form in New York, says *The Drug Abuse Report*. Dealers are looking for "brand loyalty," because of the fact there's less chance of adulterating the cocaine with other substances such as baking powder. Doctors here are worried that the pills will be mistaken for acetylsalicylic acid (ASA), or that children will swallow them. Crack users smoke the pills.

PARTY time

TORONTO — A graphic portrayal of the physical and emotional trauma brought on by an alcohol-related accident may be all it takes to prevent some of the estimated 60% of accidents involving youth and alcohol. *Ontario Hospitals Today* says Sunnybrook Medical Centre here has developed the PARTY (Prevent Alcohol Related Trauma among Youth) program, which includes a seminar with paramedics and tours of intensive care and other hospital wards. A video of the program will soon be made available to schools across Ontario.

MPs under fire

TORONTO — The Canadian Cancer Society has mounted a nationwide campaign to pressure the federal government into approving the bill to ban tobacco advertising and promotion. Canadians are urged to write their MPs in support of Bill C-51; passage through Parliament has been delayed by heavy pressure from the tobacco industry.

The 'four Ds'

ATLANTA — PADS (Prescription Abuse Data Synthesis) is attempting to stop illicit drug diversion with assistance from the "four Ds," says *Addiction Alert*. The four Ds are practitioners who are disabled, dishonest, duped, or dated. The PADS program, a thrust of the American Medical Association, has significantly reduced drug diversion in Michigan, one of the first states surveyed following the beginning of the program.

Import quality

NIGERIA — Third World countries should avoid importing substandard drugs by using the World Health Organization's facilities for quality control, says *Pharmanews* of Nigeria. P.O. Emafo of Lagos recommends that developing countries lessen the risk of importing inferior pharmaceuticals by using WHO testing facilities and establishing national quality-control laws.

No to smokeless

OTTAWA — Smokeless tobacco should be butted out, says the Canadian Cancer Society (CCS). The CCS says health problems from smokeless tobacco are endemic in the United States and the product should be banned in Canada as part of the federal crackdown on tobacco.

Dutch needle exchange worth a look

By Harvey McConnell

WASHINGTON — A needle-exchange program in the Netherlands is really worth consideration by United States officials even though there is little hard data yet on its effectiveness in stopping the spread of the AIDS (HIV) virus.

There are also no markers yet as to whether exchange of dirty needles for clean needles by intravenous (IV) users has increased or decreased drug use, or brought more people into treatment, says Ian Macdonald, MD, director, White House Office on Drug Abuse Policy and head of the Alcohol, Drug Abuse and Mental Health Administration.

Dr Macdonald, chairman of a plenary session of the 3rd International Conference on AIDS here, added in a later interview: "What does seem to work is that on any pretext, whether it is the pretext of counselling, education, or provision of needles, where the interviewer offers treatment, and treatment is available, we could lure people into treatment.

"My position (on supplying free needles) still remains that the most effective way to stop the spread of this disease is to get people off the needle."

Dr Macdonald says he is also in favor of expanding methadone maintenance.

"It is always a difficult choice between those who will say methadone is replacing dependencies — and that's true — and those who would say even though it's true, it reduces crime and increases productivity.

"I think AIDS is tipping the balance in favor of saying, now we have two arguments against one and I think countries such as Finland, which would not have thought about using methadone in years gone by, are now reconsidering."

Dr Macdonald noted that there is an added argument to put to the IV drug user who is sero-positive. "One of the co-factors of AIDS, on the basis of very early data, is reinfection. If they can prevent that reinfection, we not only offer the partners but also the people themselves a plus."

Supermodel sets drug-free example

Schnarre (left): kids look up to supermodel

By Deana Driver

SASKATOON — The celebrity everyone was waiting to see here at the PRIDE (Parents Resource Institute for Drug Education) Canada conference was Monika Schnarre, a 16 year-old, straight-A student from Scarborough, Ontario, who was also Supermodel of the World, in 1986.

Ms Schnarre told 650 PRIDE delegates that choosing a drug-free lifestyle was one of the smartest decisions she ever made — taking drugs is 'dumb.'

"The thing that scares me most is that I would have no control," she said.

Ms Schnarre also talked about lives being destroyed by drugs and added, "Knowing what it does to you keeps me away from it."

Ms Schnarre told The Journal she enjoys doing public relations work like appearing at the PRIDE conference. She put aside "maybe an assignment in New York" to attend because it was important to her.

"A lot of kids look up to me. I thought it would be really good for me just to start setting an example."

HIV transmission by addicts a major worry

(from page 1)

"This is another important reason to counsel sero-positive, IV drug users that it is important to try to avoid traditional styles of heavy use of non-sterile injections that can lead to a variety of infections such as endocarditis and non-pneumocystic pneumonia.

Dr Des Jarlais later told a press conference that traditionally society has shown moderate to little concern about IV drug users "and relatively little ability to control the IV drug use problem.

"Now, because of the devastating effects of the HIV infection and the certainty of transmission from drug users to sexual partners and children, we are in a situation where we must re-examine our traditional assumptions about IV drug users and make a significant and sustained commitment to the health of IV drug users.

"We're going to have, at some level, to take into account fatalities with HIV as a co-factor as part of the AIDS-related spectrum."

Dr Des Jarlais said he is certain, based on the New York city experience, some such increases could be as high as 100%.

"IV drug users are the main source of heterosexual and perinatal transmission in North America and Europe. If we are going to be serious about controlling this epidemic among heterosexuals, we are going to have to be serious about controlling it among IV drug users."

There are indications some IV drug users are making changes to reduce their risk of transmission, but clearly much more is needed. There is no single answer.

Dr Des Jarlais said that they should be doing a variety of things, from providing treatment for any drug user who wants it, providing counselling and education concerning heterosexual transmission for IV drug users in the US and western Europe, and providing education and means for safer injection procedures among those likely to continue injecting the drugs.

"And, we must do something to stop new people from starting to inject."

Dr Des Jarlais said he supports a New York city health department proposal to evaluate the effects of the needle exchange program. The best data at the moment come from Amsterdam where a needle-exchange program has been going on for several years.

AIDS experts: interest turns to drug users

WASHINGTON — The 3rd International Conference on AIDS here drew more than 7,000 scientists and public health officials from 50 countries. They presented some 250 reports and 2,000 poster sessions and were reported on by more than 800 members of the news media. Five years ago, most of the delegates would have had only a cursory interest in IV drug users. Today, IV drug users are considered the major threat for spreading the HIV virus into the heterosexual community.

Next month, The Journal presents complete coverage of the AIDS conference.

Alcohol hits hormones too

(from page 1)

annual meeting here of the Ontario Medical Association, Dr Van Thiel said a Pittsburgh research group has been investigating the relationships between alcohol, the liver, and sex.

Although many medical texts say that cirrhosis of the liver causes hypogonadism, they found otherwise. It isn't the liver damage that affects hormone levels, but the alcohol itself.

The 10% of cirrhotics whose disease isn't related to alcoholism have normal testosterone levels.

The energy of endocrine cells in the testes is not only diverted from making hormones to metabolizing ethanol, but one of the by-products of that metabolism, acetaldehyde, is a toxic substance.

"The cells are not dead, they are misdirected.

"It's like you're in the wrong lane in a traffic rotary. You're still in the car, but you're not getting where you want to be."

There is evidence that women who drink excessively have some gonadal effects, but they are more difficult to study, he said.

NEWS

Basic research indicates allergy tie to alcohol

'It's too early to draw firm conclusions'

By Betty Lou Lee

TORONTO — Rat research at the Addiction Research Foundation (ARF) and the University of Toronto (U of T) here indicates there may be some truth to what Alcoholics Anonymous has been saying, and scientists have been denying, for 50 years: allergy may play a role in alcoholism.

It has always been thought the alcohol molecule was too small to provoke an immune response. But, the group has shown in rats that when one molecule of alcohol is metabolized, one molecule of acetaldehyde is produced, and that can bind with protein to trigger the production of IgG antibodies — the type that go on search-and-destroy missions to protect the body.

The researchers have also now shown that these same protein-acetaldehyde complexes can trigger IgE antibodies — the ones that produce allergic reactions.

Yedy Israel, PhD, chief, ARF biochemical research and U of T professor of pharmacology and medicine, outlined the research here at the annual meeting of the Ontario Medical Association.

"Immunology research related to alcohol is only a few months old," he told **The Journal**.

It is too early to draw firm conclusions about its role in alcoholism, but there are speculative possibilities.

One is a vaccine that would produce an allergic reaction if the person drank alcohol. The reaction would be controlled to be uncomfortable but not dangerous: unlike disulfiram (eg, Antabuse), or other aversion techniques, the vaccine would not require continued patient compliance.

Immunology could also hold the key to liver damage in alcoholics. Acetaldehyde may bind to liver cells, attracting antibodies that activate killer cells that destroy the liver cells.

The research group has already produced a diagnostic test for alcoholism that works on the same principle as the hemoglobin AIC test for diabetics that measures average blood sugar levels over a period of weeks.

Their test uses an antibody that can recognize protein-acetaldehyde complexes in the blood, giving an accurate reading of alcohol consumption.

Dr Israel said it has been 80% successful in recognizing alcoholics.

Israel: speculative possibilities

Steroids' benefits to athletes may be overrated

By Harvey McConnell

CLEVELAND — Some athletes will take any drug they think will help their performance, yet there is no evidence the most widely abused drugs — anabolic steroids — work.

"I have investigated enough incidents to know there are people who will stop at absolutely nothing in order to produce a better athlete," says Donald Caitlin, PhD, MD, director of the Olympic Sports Laboratory, University of California at Los Angeles.

"And forget about ethics. They don't exist."

Timing: shooting between heart beats

One group of drugs widely abused among shooting and pentathlon athletes is beta blockers. "They are highly abused in these sports and tremendously effective as they really increase scores," Dr Caitlin told the annual meeting here of the American Medical Society on Alcoholism and Other Drug Dependencies.

Dr Caitlin: "When one has to try to hold the hand steady to shoot a bow and arrow or pistol, one millimeter of motion in your finger tip when the heart beats, translates into four centimeters of motion at the target.

"Athletes in these sports shoot between heart beats and because beta blockers slow the heart, this gives them a greater opportunity to shoot between beats."

Anabolic-steroid abuse is endemic in many sports with men taking 30 to 50 times the normal amount of testosterone produced in a male daily. Supplies come into the United States from France and Mexico. (Recently, a ring importing steroids from Mexico was broken up.)

Dr Caitlin: "One of the most remarkable things about the anabolic-steroid situation is that there is little or no evidence they work.

"So why do people take them?

"They believe it increases muscle mass and strength, reduces the muscle recovery time, and makes you more aggressive. But, there is no evidence that steroids work."

It is useless to tell athletes there is a paucity of evidence about the effects of steroids. "They will tell you you are wrong, they do work. I have heard this over and over again," says Dr Caitlin.

Canada's Olympic drug-testing laboratory The Back Page

On the other hand, studies show anabolic-steroid abuse increases the incidence of coronary artery disease, has a variety of effects on the liver, and a number of tumors, some malignant, have been associated with anabolic-steroid use.

Dr Caitlin said steroids are used not only by such athletes as body builders and weightlifters, but also in sports where one would not expect such use, including figure skating, volleyball, and tennis.

Anabolic steroids are used by some women athletes, especially long distance runners, though not usually by women in North America. "the cost in terms of their bodies is tremendous," he added.

Dr Caitlin said the object over the next four or five years is to see if quality testing really has an effect on this problem.

Ontario inmates recommending earlier drug prevention program

TORONTO — A group of inmates serving weekend sentences here has presented a brief to Ontario Premier David Peterson outlining ways to combat alcohol and other drug-related problems.

The 15-page brief, written by inmates of the Mimico Correctional Institution, urges alcohol and drug education programs be directed at children as early as Grade 1. It also suggests expert counselling begin at Grade 1, teaching children to identify abuse in their homes, to express their feelings, and how to relate to parents, siblings, and peers in an unfavorable home environment.

The inmates also requested low-alcohol beverages (less than 1% alcohol) be taken off the market and more stringent efforts be made to deny children access to cigarettes.

Other recommendations range from stiffer penalties for drunk driving to tighter eligibility controls on those who buy alcohol, to a proposal that cigarette and alcohol advertisers contribute equal amounts of their advertising dollars to a special government fund to be used for educational purposes and campaigns for a drug-free lifestyle.

"We, as addicts, find advertising that makes the consumption of alcohol appealing, very destructive to our attempts to regain control of our lives," states the brief.

The brief was written by inmates participating in the Mimico Alcohol and Drug Education (MADE) program, sponsored by Alcohol and Drug Concerns, Inc.

Teachers told 'it's your problem too'

School confronts drug situation every time

By Deana Driver

SASKATOON — A school principal here says schools should take a tough stand with young drug users from the onset, going as far as laying charges and expelling them in some cases.

Brian Hartsook, principal, Aden Bowman Collegiate, told a workshop here at the PRIDE (Parents Resource Institute for Drug Education) Canada that school staff have a responsibility to "never look the other way" if a student is suspected of using drugs.

"It's your problem, too," he said.

One of Mr Hartsook's first moves, when he became principal of a 950-student high school a few years ago, was to do a staff in-service orientation on drug abuse and what the rules of the school were going to be. Then, students were educated on the rules, which emphasize the "logical consequences" of behavior: if the behavior is positive, the consequences are positive.

Students learn right from Grade 9 that "if you come into the building under the influence of drugs, or with the odor of alcohol, or in possession, or in the act of trafficking, this is what will happen to you," said Mr Hartsook.

He admits his is not the ideal program, "but it's better than nothing at all."

If students are found with alcohol or smelling of alcohol, 24-hour suspensions are handed out and the students must come back with a parent or guardian.

Such students must sign written contracts to come back to school saying they will refrain from such activities in future, will meet with addictions counsellors, and go for treatment until the problem has been resolved.

If students are in possession of a drug, they are turned over to city police. Parents are phoned for an interview, but interviews are conducted at the police station. Students are asked to go to a local centre for treatment in exchange for the school not pressing charges.

If the offence is trafficking, the response is more severe.

"I turn you over to the police. I request a charge be laid, and we are finished with you, turkey," said Mr Hartsook.

Parents have balked at some of his tactics and have gone as high as the minister of education. But, Mr Hartsook has had support from the higher levels.

Golobitsh

School counselling: teaching logical consequences of behavior

NEWS

RESEARCH UPDATE

Chickenpox serious in smokers

Adult smokers who get chickenpox could be at risk of potentially lethal pneumonia. Three physicians with the regional department of infectious diseases and tropical medicine and the department of chest medicine, Monsall Hospital, Manchester, England, report the cases of 29 adults admitted to hospital between March, 1985 and February, 1986 with chickenpox. Of 19 patients who were current or recent smokers, seven had pneumonia, which can kill up to one in five adult chickenpox patients. Of the 10 patients who had never smoked, none had pneumonia. Twenty patients underwent lung function tests; of the 12 smokers or ex-smokers tested, five developed pneumonia, and another three had an abnormal carbon monoxide transfer factor, which the reseachers think is due to subclinical chickenpox pneumonitis. Only one of the eight non-smokers had an abnormal reading, and she had a history of extensive pulmonary tuberculosis. All of the pneumonia patients were successfully treated with intravenous acyclovir (eg, Zovirax) for five days. The physicians conclude clinicians should consider giving acyclovir to adults with chickenpox who smoke.

British Medical Journal, April 18, 1987, v.294:1002.

Eye drop drug test unreliable

Work by two Florida physicians has countered European claims that naloxone drops placed into one eye can be used to detect opiate dependence without causing intense withdrawal effects. It had previously been reported that ophthalmic instillation of naloxone into one eye could produce anisocoria (a change in diameter of the pupil) without other signs of dependence in opiate-dependent subjects. Researchers from the department of neurology, University of Miami, placed naloxone into the conjuntival sac of one eye in each of four volunteers currently on methadone maintenance. They found administration of 0.4 milligrams of naloxone had no impact on pupillary diameter, but when 4 mg of naloxone was instilled one week later, each of the patients exhibited bilateral dilation of the pupils, and one showed anisocoria up to 30 minutes after administration of the drug. All four subjects reported feeling 'uneasy;' two exhibited tachycardia, and one patient was sick and had other gastrointestinal symptoms. Three healthy, non-opiate dependent volunteers who acted as controls had no change in pupillary diameters with either dose of the drug. Drs J. Sanchez-Ramos and Edward Senay conclude ophthalmic instillation of naloxone could not successfully detect opiate dependency without potentially causing a complete withdrawal syndrome. They say it should not be used on a routine basis for the detection of opiate dependency.

British Journal of Addiction, March, 1987, v.82:313-315.

Addiction undiagnosed in elderly patients

A high proportion of elderly psychiatric inpatients have chemical dependency that goes unrecognized, say two physicians. Drs Scott Whitcup and Frank Miller, University of Los Angeles and Cornell University Medical College respectively, looked at the patient records of 90 patients older than 65 years, admitted to the Payne Whitney Clinic in New York. Admissions were primarily for severe depression and organic mental disorders. The doctors used a rigorous set of criteria to diagnose drug dependency and withdrawal including clinical signs, a positive history of dependence, or positive blood and urine drug screens. Of the 90 patients evaluated, 21%, or 19 patients, were defined as chemically dependent; 10 were neither recognized nor detoxified. Of the dependent patients, seven of 10 patients who were not detoxified, but only one of the nine detoxified patients, experienced serious medical complications requiring transfer to a medical floor or an intensive care unit. While male alcoholics were likely to be identified as chemically dependent, female benzodiazepine abusers often went undiagnosed. Seventeen of the 19 dependent patients gave histories consistent with dependence; the other two had blood and urine screens positive for drugs. Their findings, Drs Whitcup and Miller say, "illustrate the need to appreciate the frequency of chemical dependence and withdrawal in psychiatrically hospitalized elderly who may be inadvertently deprived of their drug regimens."

Journal of the American Geriatric Society, April, 1987, v.35:297-301.

Alcohol hinders hypertension therapy

Alcohol, by raising blood pressure, interferes with hypertension treatment. Following-up on earlier work showing alcohol is directly responsible for raising blood pressure in normotensive individuals, Australian researchers used a randomized, controlled, crossover study to look at its impact on men being treated for essential hypertension. In the study, 44 men defined as moderate to heavy drinkers were divided into two groups and either continued their normal drinking habits for six weeks or were asked to drink only a brand of beer with an alcohol concentration of 0.9% for the same period. The alcohol consumption of the two groups was then reversed for a similar six-week period. Throughout the study, the subjects continued their usual antihypertensive treatment. Blood pressure and body weight measurements were taken during the study as were blood samples for enzyme and lipid analyses. A daily diary was kept to monitor alcohol consumption which dropped from a baseline average of 452 millilitres ethanol weekly to 64 ml ethanol weekly when subjects were in the low-alcohol phase of the study. The three researchers from the department of medicine, University of Western Australia, and the Royal Perth Hospital, Perth, found that mean systolic and diastolic blood pressures were significantly lower during the last two weeks of the low-alcohol period than during the normal alcohol period.

The Lancet, March 21, 1987, no:8534:647-651.

Pat Rich

AIDS-drug distribution assured under new federal/provincial plan

By Kate Fournis

OTTAWA — The Canadian government has reached agreement with a pharmaceutical company to make the drug zidovudine available to a broader number of AIDS patients without licensing it for prescription sale.

In May, Burroughs Wellcome Inc started charging the government for the drug (formerly called azidothymidine or AZT) and threatened to stop supplying it unless it was licensed.

Federal health officials were concerned that because supplies of zidovudine are limited, giving it prescription-drug status might mean the drug would not reach those who need it most.

The new agreement will permit zidovudine to be given not only to AIDS patients with *pneumocystis carinii* pneumonia, but also to those patients with other opportunistic infections of viral, parasitic, and bacterial origin and to those with "severe, symptomatic, AIDS virus infection and a low T4 cell count," says federal Health Minister Jake Epp.

The drug will continue to be distributed by clinical investigators in each province; they will also continue to collect data on its efficacy and safety.

When the agreement was reached in late May, federal and provincial health officials were working out financing and distribution questions.

The government agreed to pay for the drug — estimated to cost about $10,000 for a year's supply — only until the end of May. The provinces had to come up with financing arrangements then.

Because the drug is in short supply, federal and provincial health officials are devising a hierarchy of indications for its distribution. That hierarchy will be made uniform across Canada.

The company and health officials "acknowledged the need to provide the growing, but still limited, supplies of the drug to those most in need and agreed that allocation will be made to the provinces according to the number of reported AIDS cases," Mr Epp said.

Burroughs Wellcome has agreed to make zidovudine available internationally.

The Canadian supply will gradually increase by the end of 1987 to about double the level available in June, says Greg Smith, coordinator of the National AIDS Centre here.

For June, that represents 500 to 600 patient-years of drug, he estimates.

Throat cancer tied to stomach acid

Smoking prompts reflux action

By Paul Szabo

DENVER — A link between cigarette smoking and throat cancer could well be that smoking encourages regurgitation of stomach acid into the throat.

The theory was made independently here by two physicians presenting papers at the spring meetings of the American Academy of Otolaryngology, Head and Neck Surgery.

The regurgitation of stomach acid — gastroesophageal reflux —was identified by a research group from Wake Forest University Medical Center, Winston-Salem, North Carolina, as the probable cause of a number of throat conditions, including laryngeal cancer.

And, Murray Morrison, MD, professor of surgery at the University of British Columbia, Vancouver, linked reflux with glottic cancer.

Dr Morrison and James Koufman, MD, who headed the Wake Forest research group, said there is strong evidence to suggest the promotion of reflux by smoking can be responsible for some throat cancers.

Dr Morrison said nicotine relaxes the lower esophageal sphincter and allows stomach acid back up into the throat, so heavy smokers probably are promoting reflux in themselves. Dr Koufman said studies show reflux occurs two-thirds of the time when people smoke.

Golobitsh

Significant cancer factor: initiated by smoking

Both physicians say it isn't yet clear exactly how reflux could cause cancer. Dr Koufman noted experimental studies show leaving acid in contact with the lining of the throat can lead to chronic inflammation and that this could lead to cancer.

"It may be that acid reflux is a significant factor, and it's initiated by smoking cigarettes."

Dr Morrison cautions that reflux is a common problem, especially in the 10% of the population who suffer from a hiatus hernia.

"We wouldn't want to get to the point where everybody who has a hiatus hernia . . . suddenly starts thinking, 'Oh my goodness, I better start thinking about the possibility of getting (throat) cancer.' "

On the other hand, he said, the evidence "would certainly suggest anybody with a hiatus hernia shouldn't smoke."

Little change in college drinking

By Paul Szabo

DENVER — College-age women in the United States are drinking more and drinking more heavily, but the trend is not dramatic and the women are still behind their male colleagues.

That's the conclusion of Ruth Engs, MD, who has been conducting research into women and drinking in college since 1974. She reported her findings here at the 1st National Conference on Women's Issues, coordinated by the Alcohol and Drug Problems Association of North America.

"Students aren't doing anything more than when I was a gradnate in the late 50s," said Dr Engs, department of applied health science, Indiana University.

While the media indicate there has been an alarming increase in alcohol consumption by college students in the past decade, there has actually been only a small increase.

"On the whole, we're not looking at any dramatic change," she said.

There is at least one statistic among Dr Engs findings that indicates there has been more than a small increase: female heavy drinkers, those who consume at least a six-pack of beer at one sitting once a week or more. The number of women falling into this category has risen to 11.8% from 4.4% in 1974.

Dr Engs started collecting data on college-age drinking habits in 1974, and, in both 1982 and 1985, collected information from more than 5,000 students from 81 US post-secondary institutions of different sizes, in every state. About half of the respondents were women.

The surveys show the continued tendency of male students to be more likely to drink, to drink more often, to consume more alcohol, and to experience more drinking problems than women.

While this gap may be narrowing slightly, Dr Engs wrote in a paper with sociologist David Hanson of State University of New York College, it remains "clearly significant and potent."

COCAINE

Paraphernalia clues to drug-based heart attack

By Betty Lou Lee

HAMILTON — Drug paraphernalia are often the only hint emergency room staff get that a heart attack is due to drug abuse, says James O'Brien, MD, PhD, chairman of the medical committee for the International Narcotic Enforcement Association.

A small mirror, a straw with white powder on it, a single-edged razor blade with a cardboard cover, a gold spoon on a chain around the neck, or a small spoon in a pocket can indicate a cocaine user, he told emergency personnel at the McMaster University Medical Centre.

A single long fingernail, usually on the small finger, may also be used as a coke spoon.

Dr O'Brien, also assistant professor of psychiatry and medicine, University of Connecticut School of Medicine, Hartford, said heart attacks are common at any age with cocaine use (**The Journal**, February, 1986). Pneumothorax with lung collapse, mediastinal emphysema, and lactation without pregnancy can be other sequellae.

Cocaine can also cause *abruptio placentae*, where the placenta ruptures and both mother and baby die.

Black needle tracks are "rapidly becoming passé" as an indicator of intravenous drug use, he said. The black marks were carbon from the end of a needle that was held in a flame to sterilize it. But, the switch to disposable needles because of fear of AIDS has eliminated the tell-tale marks.

Dr O'Brien warned of the sophisticated manipulation narcotic addicts can use to get prescription drugs in emergency departments.

One man needed immediate relief from the excruciating pain of kidney stones. His urine sample had the appropriate amount of blood because he pricked his finger while collecting it. Even the x-ray confirmed the 'stone' — no one noticed he had a spot of leaded paint on his back above the ureter.

"The addict will also say he's allergic to everything but the drug he wants, usually Dilaudid (hydromorphone)."

Dr O'Brien said few cocaine users have holes in their noses from snorting the drug: "I've seen more from people who work in battery plants."

But, they usually use only one nostril, and that one will have swollen membranes. Mucus also tends to cake in that nostril because of the decreased blood supply.

Crack and cocaine ARE same

HAMILTON — Crack and cocaine are now being treated incorrectly in the public mind like two separate substances, crack the more dangerous.

James O'Brien, MD, PhD, chairman of the Medical Committee for the International Narcotic Enforcement Association, points out: "Anything that applies to crack also applies to hydrochloride, and all the deaths I've seen have been hydrochloride, but that is not getting out to people."

Another popular belief is that cocaine is not effective if taken orally. But, those who "eat their stash" to avoid arrest will have the same blood level in 60 minutes as if they had injected it.

There have been a number of deaths in his hospital where people showed no symptoms immediately after ingesting cocaine.

Dr O'Brien: "You think after 20 minutes they're all right, and they die on the way out the door."

'Precipitous' increase in crack complications

Neurological, psychiatric problems seen more and more frequently

By Katherine Lake

NEW YORK — Crack is living up to predictions it would become the most dangerous drug to hit the United States streets since widespread heroin abuse hit in the 1960s.

The cheap and widely available alkalinized cocaine started to seduce the youth of urban ghettoes a couple of years ago; now, crack is widely abused by people of all ages, at all socioeconomic levels.

Lisa Benson, administrator of the US National Cocaine Hotline (1-800-COCAINE), says about half of the 1,200 daily calls involve concerns about crack. And, most of these calls are from people having personal difficulty with the drug.

Hotline workers estimate two million US residents have tried crack and the number grows by about 2,000 new smokers every day.

With the rise in crack abuse, doctors are starting to see a "precipitous increase" in the neurological and psychiatric complications associated with cocaine use.

"Crack is proving to be a very dangerous drug," Mark Goldberg, MD, told **The Journal** at the annual meeting here of the American Academy of Neurology.

"Whereas we used to see the odd seizure or stroke from intranasal or intravenous cocaine use, we're seeing such complications more and more frequently as crack abuse grows."

Within the past two years, Dr Goldberg, professor of neurology and pharmacology, and colleagues at the University of California, Los Angeles (UCLA) School of Medicine have seen 19 people — 15 of them crack users — with neurological or psychiatric complications attributed to cocaine abuse.

Goldberg: spinal cord wipe-out

"We're seeing crack users with irreversible brain damage from strokes," Dr Goldberg said. "We're also seeing serious psychiatric disturbances in people with no known psychiatric history.

"I fear this is just the tip of the iceberg. As more people try crack, we will see these problems more frequently because smoking crack is more dangerous than doing cocaine hydrochloride either intravenously or intranasally."

When cocaine is snorted, the drug's inherent vasoconstrictive properties eventually shrink the blood vessels in the nose, limiting the amount of cocaine that is absorbed systemically during a snorting session, Dr Goldberg said. But, since crack is smoked, "the hit to the brain is much more direct and is not diminished with repeated doses."

The patients in the UCLA series ranged in age from 18 to 45 years, and almost one-third were first-time crack users. Neuropsychiatric complications were associated with acute use in 58% of the patients and with chronic use in 42%. Complications occurred within minutes to three hours after crack use.

The most serious complication was permanent paralysis from an anterior spinal artery infarction in a 24-year-old crack user. "This case shows crack can wipe out the spinal cord," Dr Goldberg said.

Other neurological complications included strokes in various parts of the brain, hemorrhage into the brain, generalized tonic-clonic seizures, and transient ischemic attacks — warning signals of an impending stroke.

GILBERT

Drugs and jet lag

Nature's End: The Consequences of the Twentieth Century is a horrifying glimpse at the year 2025 by Whitley Strieber and James Kuneta. The atmosphere is dying. Cities teem with choking wretches. In oceans of decaying, pullulating humanity are islands of splendor where elites are buttressed from the ecological mess by extraordinary technology. Transatmospheric vehicles (TAVs) whisk the privileged from one island to another — from Los Angeles to Calcutta, for example, in under three hours. 'Tavving' requires the use of equalizers — drugs that rush the user through hours of metabolic activity in minutes.

Most of the ingredients of this nightmare are in place. Tropical forests are being razed: their sparse soil is becoming desert. Forests in Europe and North America die from acid rain. Topsoil everywhere blows away from overuse. Democracies die as underclasses emerge and the wealthy resume their ascendancy.

Do we already have equalizers?

I happen to have flown more than 250,000 kilometres during the last 15 months, across the Atlantic and the Pacific, and often touching one or another North American coast. A book by Dr Charles F. Ehret and Lynne Waller Scanlon entitled *Overcoming Jet Lag* has been much in evidence at airport bookstores. These authors suggest pharmacological manipulation of human circadian rhythms is already possible.

Dr Ehret and Ms Scanlon outline a three-stage program for overcoming jet lag used, we are told, by the United States president. ("Thank you for your fine contribution to humanity," reads an endorsement from the White House.) The three stages are the four days before a flight, the flight itself, and the day after the flight.

Key variables, say these authors, are light, diet, and caffeine use.

Current interest in pharmacological manipulation of body clocks centres on melatonin . . .

Light is important during and after the flight, they say. Lighting during the flight should be that of the destination. Throughout the next day, natural lighting should be experienced to the full — no sunglasses, darkened rooms in daytime, or lit rooms after sunset. The objective is to entrain the body as quickly as possible to the new solar rhythm.

Diet is important, say Dr Ehret and Ms Scanlon, because foods rich in protein act as stimulants and foods rich in carbohydrates act as depressants. Also, when glycogen levels are low, as after fasting, external 'zeitgebers' (timegivers) more readily influence the internal diurnal cycle. The authors thus recommend eating high-protein meals early in the day and high-carbohydrate meals late in the day, and alternating between high and low food intake over the five days of the regimen so that the day of the flight is a low-intake day and the next day is a high-intake day.

Caffeine is said to act in two ways. Its use causes depletion of glycogen, thus enhancing sensitivity to external zeitgebers. More directly, caffeine may shift the body clock forward or backward, according to when it is used.

The suggestion of a direct effect of caffeine came from preliminary work on the effects of the related drug theophylline (found in tea) on the circadian rhythms of rats, reported by Dr Ehret and two colleagues in the journal *Science* in 1975. This work indicates that caffeine given to a human in the morning might reset the body clock to an earlier time; in the afternoon, the drug would have no effect; in the evening, caffeine might set the clock forward.

Thus, for flights involving a five-hour time change, Dr Ehret and Ms Scanlon recommend abstention from caffeine during the days before the flight (to enhance the effect) and consumption of three cups of strong tea or coffee all at once on the day of the flight. For eastbound flights, the caffeine should be consumed in the evening an hour or two before the flight to help the body skip over the missed hours. For westbound flights, the caffeine should be consumed in the morning to help the body adjust to the lengthened day.

In January this year, I took a party of civic officials and environmentalists to Europe to study refuse incinerators. Warnings about the intensity of our itinerary and the ills of jet lag, and advice about possible prophylaxis, were not enough to induce even one of the 11 participants to follow the complex schedule of eating and drinking proposed by Dr Ehret and Ms Scanlon. My attempt to provide data for this column failed.

More formal attempts may have encountered similar difficulties: little has been published on drugs and jet lag. One report concerns theophylline and changes in human sleep cycles. A bimodal effect according to time of administration was not evident. No report has concerned caffeine. Many studies show caffeine given in the evening *delays* sleep onset. A day-shortening effect seems improbable.

Current interest in pharmacological manipulation of body clocks centres on melatonin, the skin-lightening hormone secreted by the pineal gland each night. Last year, Dr Josephine Arendt and two colleagues noted in the *British Medical Journal* that six of nine subjects who took a placebo reported jet lag symptoms after flights from San Francisco to London (eight-hour difference), but none of eight subjects who took evening doses of melatonin before and after their flights reported symptoms.

Debate continues as to the mechanism of such an "equalizing" effect of melatonin, and, as to the value of speedy meridian hopping.

By Richard Gilbert

LETTERS

Trauma of abuse eased by life skills training

Children of alcoholics

Alberta Hospital Edmonton has been running a life skills training course for the past 11 years. This 240-hour training course teaches students the basic problem-solving skills necessary to cope not only in interacting socially with others daily, but also in resolving personal conflicts.

Many of the students who complete this 16-week course have been raised in a home where one or both parents are alcoholic. Stories of physical and sexual abuse are common, not to mention the hours of neglect each had to endure.

In spite of the trauma suffered, many graduates of the life skills program have continued to do well on completion of this course. The daily atmosphere of unconditional acceptance, appropriate problem skills, listening, and description of feelings has bolstered the damaged self-esteem of many. I believe this program gave hope where little had previously existed.

I would greatly appreciate if you could supply me with a bibliography on adult children of alcoholics if you have any available. As well, would you be able to supply me with an address for the United States National Association for Children of Alcoholics? The knowledge gained from this growing field of study will greatly enhance the welfare of individuals undergoing treatment at this centre.

William Hanec
Alberta Hospital Edmonton
Psychiatric Treatment Centre
Edmonton, Alberta

* * *

We are interested in joining the Canadian Association for Children of Alcoholics and would appreciate any information you can provide regarding membership.

Greg Howse
Executive director
Simcoe Outreach Services
Barrie, Ontario

* * *

I am very pleased to hear that a Canadian association has been founded for children of alcoholics (**The Journal**, December).

In my present position as program supervisor of our out-patient clinic for substance abusers, I am able to promote the awareness of children of alcoholics in our community and to develop programs to meet their needs.

If I can in any way participate at a national level in this very exciting and overdue venture, please let me know. I would also appreciate receiving all the information available on the Canadian Association for Children of Alcoholics.

* * *

Christine Moores
Program supervisor
Phoenix Centre
Kamloops Society for Alcohol and Drug Services
Kamloops, British Columbia

* * *

Would you please send me information about children of alcoholics?

I would appreciate any information you have on the new organization, CACOA.

Evelyn Ahola
Teacher
North Bay, Ontario

* * *

With reference to your article on the Canadian Association for Children of Alcoholics (January), we are very interested in receiving more information.

Please send us all you can, and thank you.

Janice R. Madill
Library, Ministry of Social Services and Housing
Vancouver, British Columbia

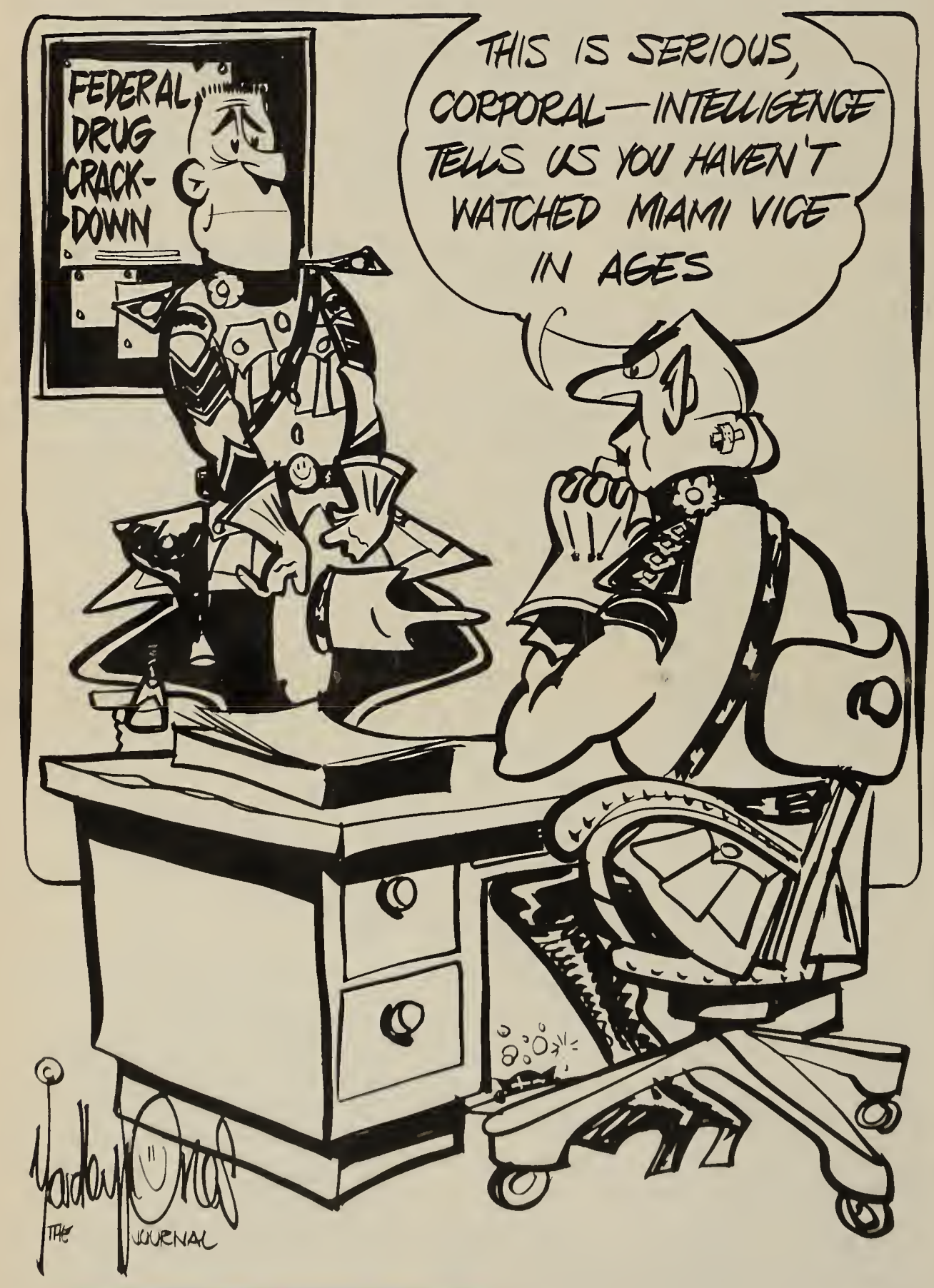
* * *

I would very much be interested in receiving any information you might have on CACOA (January).

What specifically can I do to be of service in my capacity with the Alcoholism Foundation of Manitoba?

Donald P. Richmond
Alcoholism Foundation of Manitoba
Gilliam, Manitoba

(Ed note: An information packages are on the way.)



The Journal *honored for contribution to field*

CLEVELAND — The Journal has received a special merit award in the 5th annual Markie Awards for alcoholism and addiction communication.

The award is sponsored by the United States National Foundation for Alcoholism Communications (NFAC), Seattle, Washington.

Stephanie Abbott, NFAC president, told The Journal the special recognition award is "an honor bestowed by the judges panel on an entry deserving of particular merit.

"The Journal's many contributions to the field of alcoholism and addiction throughout North America were cited. Its clarity, authority, and reputation make it a highly-significant, full-scale periodical .... Special recommendation seemed to be the best expression of appreciation and esteem that the panel had to bestow," Ms Abbott said.

The New York-based, US National Association of Junior Leagues' media campaign, *Woman to Woman*, won the sweepstakes award in the competition with several top entries. Awards were presented at the National Council on Alcoholism's annual forum here.

The Journal

A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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• Behind these pages

TORONTO — A national drug strategy for Canada has been discussed, considered, wished for, dreamed about, and delayed for years. Now, finally, it's here. What events preceded the strategy announced by Ottawa at the end of May? How do the components fit into the addiction field as it exists now? And, what do experts in the field think should happen next? The Journal editors prepared this analysis for readers: • events leading up to the strategy, from The Journal coverage since 1972 (Evolution); • testimony given to a House of Commons committee (Climate, Concerns); and, • an international perspective (World stage).

The Journal

Canada's drug strategy

• Strategy

May 25, 1987: Federal Health Minister **Jake Epp** announces in Toronto that the federal government is launching a $210-million, five-year plan to curb drug abuse, covering six areas — treatment ($81.9 million), education and prevention ($69.3 million), enforcement and control ($39.9 million), information and research ($10.5 million), international cooperation ($6.3 million), and national focus ($2.1 million).


Epp

Solicitor-General

May 26: Federal Solicitor - General **James Kelleher** announces in Montreal that the Royal Canadian Mounted Police will increase efforts to keep drugs out of Canada, knock profits out of trafficking, and increase international liaison.


Kelleher

Youth

May 26: Federal Youth Minister **Jean Charest** announces in Montreal the government recognizes the role of community-based organizations and outlines provisions for new educational material, a public-awareness media campaign, a Drug Awareness Week, and support for provincial community projects.


Charest

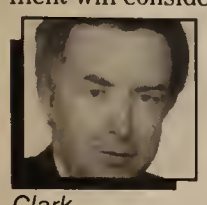
Revenue

May 27: In Halifax, federal Minister of National Revenue **Elmer MacKay** announces Canada Customs will be given "significant new resources" to fight drug trafficking.


MacKay

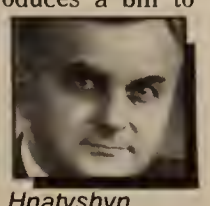
External Affairs

May 28: Federal External Affairs Minister **Joe Clark** announces in the House of Commons that the government will consider requests from narcotics - producing countries for development assistance and give $500 million to the United Nations Fund for Drug Abuse Control.


Clark

Justice

May 28: Federal Attorney-General **Ray Hnatyshyn** introduces a bill to seize, freeze, and forfeit the proceeds of crimes. New offences dealing with the laundering of crime proceeds are included.


Hnatyshyn

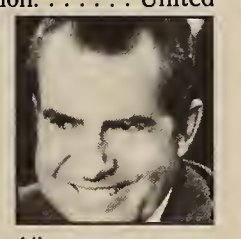
• Evolution

1972-1987 — backgrounders from The Journal

• 1972

A headline in the first issue of **The Journal** reads: Federal drug directorate in limbo — Dr Craig resigns. **William Craig**, chief of the federal Non-Medical Use of Drugs Directorate, and some 42 directorate staff were finding it hard to reconcile their mandate to get something going with leaving the government free to react to the report of the LeDain Commission of Inquiry into the Non-Medical Use of Drugs Health Minister **John Munro** had said the government would be studying a preliminary report carefully in the coming weeks. . . . . Ottawa decides against legalizing possession of cannabis but intends to discourage use of the drug while lessening the impact of the law, especially on possession. . . . . United States President **Richard Nixon** commits his government to "global war on drugs. I consider keeping dangerous drugs out of the United States just as important as keeping armed enemy forces from landing in the US." . . . . .

Munro


Nixon

• 1973

Alex B. Morrison, MD, assistant deputy minister of Health and Welfare leads a new federal thrust against drugs — implementing programs of methadone controls, tighter monitoring of physicians' amphetamine-prescribing habits, and trying to breathe new life into the Non-Medical Use of Drugs Directorate. "Our aim is to work in cooperation with the provinces. . . . We see ourselves in the sponsoring of research, in helping people provide new approaches to treatment and rehabilitation. Once they show their long-term worth, then these programs must be turned over to the people who will be running them." . . . . . The minority Liberal government of **Pierre Trudeau**, through Health Minister **Marc Lalonde**, keeps action on hold, pending the release in December of the final report of the LeDain Commission. . . . .


Lalonde

• 1974

The Bureau of Dangerous Drugs publishes the first government estimates of the number of drug users known to Ottawa. The Bureau has records accumulated during the past seven years of 68,378 cannabis users, (23,251 of them recorded in 1973), compared to 8,904 heroin users. In 1973, some 15,600 Canadians were given criminal records for simple possession of cannabis; another 2,984 were given either an absolute or conditional discharge for possession. . . . . At the United Nations Committee on Narcotic Drugs (CND) in Geneva, Inspector **G.L. Tomalty**, chief, Drug Enforcement Branch, Royal Canadian Mounted Police (RCMP), tells delegates drug abuse is a major social problem in Canada. "As most of the drugs are smuggled in from other countries, Canada can be regarded as a victim." . . . . . The third chief in three years of Canada's Non-Medical Use of Drugs Directorate is **Ronald Draper.** With the provinces responsible for treatment, rehabilitation, and the major instruments of prevention, "what we have to come up with is a role that reinforces provincial activity." . . . . . .


Draper

• 1975

In the US, the cost to taxpayers of drug abuse is estimated at $10 billion in 1974. . . . . .

• 1976

A McMaster University, Hamilton, Ontario study reveals "galloping consumption of medical drug use among Canadians," and warns physician-induced drug abuse may be emerging as a "socially significant phenomenon.". . . . . .

• 1977

The US announces it will move to a global rather than national concern with drug problems. . . . . **Mr Lalonde** says cannabis will stay in the Criminal Code. . . . . The World Health Organization (WHO) designates Ontario's Addiction Research Foundation (ARF) as one of its first Collaborating Centres for research and training in drug dependence; it's a recognition of the Foundation as a major centre of excellence in the field internationally. . . . . .

• 1979

Donald Smith, PhD, senior scientist, International Health Services Division, Health and Welfare, and chairman of the UN CND, calls at the UN for concerted international action to reduce demand for drugs. . . . . Canada slashes its contribution to the United Nations Fund for Drug Abuse Control (UNFDAC) to $100,000 from the $200,000 a year provided during the past seven years. . . . . Total narcotic consumption, licit and illicit, has risen 25% in Canada since 1971. . . . . For the first time in 33 years, Canada loses its place on, and thus, its influence on the direction of the "world parliament of drugs," the UN CND. . . . . .


Smith: reduce demand

• 1980

Canada's **Dr Smith** helps frame a major resolution for international cooperation on drug control; the resolution reflects his and other Canadian experts' emphasis on the importance of both reducing the demand for illicit drugs and shutting down supply or production. The resolution is adopted by the Third Committee of the UN General Assembly. . . . . North America prepares for a new wave of high grade heroin from the troubled Middle East. . . . . International heroin control is a question of political will, agree delegates to the UN CND. . . . . .

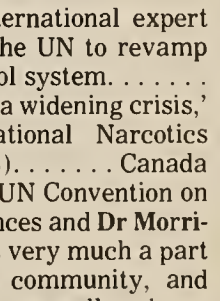
• 1981

Drug crime 'multinationals' are increasingly prominent in the news. . . . . An international expert committee calls on the UN to revamp the world drug control system. . . . . Heroin in the west is 'a widening crisis,' reports the International Narcotics Control Board (INCB). . . . . Canada prepares to sign the UN Convention on Psychotropic Substances and **Dr Morrison** says: "Canada is very much a part of the international community, and has to be seen to be, as well as be, a good citizen . . . for this country to accede . . . to the convention has a symbolic value." . . . . . Cocaine convictions are on the upswing in Canada. . . . . Announcing a joint federal/provincial task group on alcohol and youth, **Mr Draper**, now chief, Health Promotion Directorate, Health and Welfare, says: "Our ideal would be a very cohesive, country-wide strategy that would serve as a collective national reference." . . . . .

• 1982

Nancy Reagan, wife of US President **Ronald Reagan,** recalls she was, "genuinely stunned by the magnitude of America's drug problems" during the 1980 presidential campaign. . . . . **Ross Ramsey**, months into his presidency of the long-ailing Canadian Addictions Foundation (CAF), wants to make the CAF the "national voice of the field in Canada." . . . . . The RCMP anticipate heroin, cocainc, "chemical drugs," and marijuana — in that order — will be their priorities this year. Superintendent **Rodney T. Stamler**, officer in charge, Drug Enforcement Branch, RCMP, predicts: "There'll be more supply, more experimentation, more addicts, and more overdose deaths." . . . . . In the US, **President Reagan** sets up a well-armed task force to tackle "rampant crime and epidemic drug smuggling in south Florida." . . . . . Drug abuse and trafficking worldwide have now


Reagan


Ramsey


Stamler


Reagan

(continued on page S2)

Canada's drug strategy

• Evolution

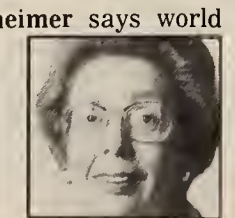
1972-1987 — backgrounders from The Journal

(from page S1)

reached staggering dimensions and grow worse annually, agree delegates to the UN CND. Cocaine traffic is continuing its "inexorable expansion." . . . . . Following the US clampdown in Florida, the RCMP are on alert for drug criminals seeking new bases of operation here. . . . . The US is targeting producers and traffickers in its federal strategy, but officials in developing countries — producer countries — say crop eradication programs threaten their negotiations with farmer/producers and are also, "a waste of time and money." . . . . .

• 1983

Canada prepares to launch a three-year, $2.1 million, drug education campaign (Stay Real) aimed at teenagers and parents and restricted to health messages. "We're not entering legal or political areas," says a government communications officer. . . . . At a meeting in Toronto, **Norman Sartorius**, director, WHO mental health division, calls for a set of ground rules for collaborative international work, including rules that would prevent "exploitation in" and of developing countries by developed countries. . . . . In their first Drug Intelligence Estimate, the RCMP say illegal drugs in Canada generated more than $8 billion in retail sales in 1982. . . . . Convictions in Canada involving cocaine have jumped 30% in a year. . . . . In her debut as director of the UN Division of Narcotic Drugs, which has moved from Geneva to Vienna, **Tamar Oppenheimer** says world drug trade is at an all time high, and multiple drug abuse is "an increasingly common and damaging phenomenon." . . . . .



Oppenheimer

The Canadian team in Vienna, this year in the role of observer-nation, is nevertheless instrumental in drafting a "compromise resolution" that will keep benzodiazepines under scrutiny. . . . . The Canadian International Development Agency approves $244,706 for a four-year project to establish basic health care services for the opium producing villagers of northwest Thailand. . . . . More cocaine than ever is entering Canada. . . . . After four years off the CND, Canada's delegation leader **Donald Smith** predicts Canada's return to the Commission could stimulate more interest in reducing worldwide demand for drugs. . . . . **Eve Beck**, chief of Canada's youngest provincial alcohol and drug commission, in Newfoundland and Labrador, says provinces must join forces. "Most of the issues facing the provinces are not just provincial, they're national concerns." . . . . . Meanwhile, provincial chiefs are considering a national body, while agreeing the CAF is also necessary as a national voice. . . . . .

Beck

• 1984

Financial, legal, and enforcement officials from nine countries, including Canada, ask the UN to formulate a world drug control treaty aimed at eliminating the fabulous profits now accruing to drug traffickers. . . . . Diazepam (eg, Valium) and 32 other benzodiazepines are brought under international control. . . . . .

• 1985

Canadian enforcement statistics on cocaine are "almost doubling" as we go, say the RCMP. . . . . "(Drug) availability is more widespread, traffickers are more organized, and there is little sign that illicit markets for most drugs are saturated," says **Mrs Oppenheimer**. . . . . Governments agree the need to halt production and traffic has now moved beyond being a moral defence or public health issue and is one of national security for some countries. The 40-member countries of the UN are unanimous: the "war on drugs" must be carried by all governments to a tough new level. . . . . **Mila Mulroney**, wife of Canada's prime minister, joins the spouses of 16 other national leaders at a meeting called by **Nancy Reagan** to discuss drug problems among youth. . . . . **Eloise Opheim**, co-founder and executive director of PRIDE (Parents Resource Institute for Drug Education) Canada, says Canada needs more student data and more treatment. . . . . **Javier Perez de Cuellar**, UN secretary-general, calls on all countries to show commitment at senior levels of government to reducing drug abuse and trafficking. He wants a high-level meeting in 1987. Canada's **Donald Smith** calls the move "a very major initiative. Now we'll have to see if it gets off the ground. Governments are going to have to decide." . . . . .

Mulroney

• 1986

Experts are alarmed at the spectre of synthetic "microchip" drugs that could revolutionize illicit production and overwhelm enforcement efforts. Says **Jacques LeCavalier**, director of Canada's Bureau of Dangerous Drugs: Some already produced are 1,000 times more potent than heroin. . . . . "We haven't got a hope of success against drug abuse and drug problems without coordinated action — nationally and internationally," says **H. David Archibald**, president of the International Council on Alcohol and Addictions and ARF founder and a former director. "Drug traffickers . . . have it in their power to change the political map of the world." By contrast, the addictions field "is rife with territorialism." . . . . . **Mrs Oppenheimer** is appointed secretary-general of the international ministerial-level conference on drug abuse to be held in Vienna in June, 1987. . . . . A new world treaty against trafficking is given the go-ahead by the UN. . . . . Health ministers or their deputies from 30 countries issue a joint call from a London meeting for more concerted action against drugs. . . . . Health and enforcement programs are both integral to drug abuse control at local, national, and international levels, writes **Bror Rexed**, a former director-general of the National Board of Health in Sweden and a former member of the UN INCB, in a special feature in **The Journal**: The Making of a National Drug Abuse Control Policy. . . . . The need for mutual assistance and collaboration, nationally and internationally, has never been greater, writes **Mr Archibald**. . . . . **Donald Smith,** now retired, writes that it's up to **Health Minister Jake Epp** whether Canada develops a national drug strategy. "There have been several beginnings of attempts by people in middle levels of the federal bureaucracy — those who understand the highly complex field of illicit drug control. . . . However, those attempts have failed." . . . . . Prevention takes centre stage in the US. . . . . In an aside, Prime Minister **Brian Mulroney** says Canada's drugs problems are "epidemic." . . . . . **Mr Epp** says the issue had already moved up on the federal agenda. . . . . **Mr Epp** sets up an inter-departmental secretariat in Ottawa to develop a national strategy. More than 200 consultations will take place with the provinces and other experts and groups across Canada. . . . . .

Rexed

Mulroney

LeCavalier

Archibald: coordinated action

• 1987

Because delegations will be headed by cabinet ministers, the International Conference on Drug Abuse and Illicit Trafficking (ICDAIT) in Vienna in June will provide "a unique opportunity for decision making," says **Mrs Oppenheimer**. . . . . Canada's national strategy is announced by **Mr Epp** on May 25. Action on Drug Abuse/Contre les Drogues is a $210 million, five-year plan. Money will go to six key areas: treatment, education and prevention, enforcement and control, information and research, international cooperation, and national focus. . . . . **Mr Epp** leads Canada's delegation to ICDAIT. Canada also accedes to the Convention on Psychotropic Substances (1971). The official Canadian delegation includes **Joan Marshman**, PhD, president of Ontario's ARF, which, in 1989, will celebrate 40 years in the field as a provincial, national, and, finally, an international resource; and **Marvin Burke**, chief of Nova Scotia's Alcohol and Drug Dependency Commission, another of Canada's oldest commissions.

• Climate

OTTAWA — The national drug strategy was a months of consultations between a federal, interm secretariat and officials of the provincial addiction other experts in the addictions field.

But, the secretariat was not the only federal grou experts. The Standing Committee on National Heal — an all-party, House of Commons committee he nesses on drug-related issues beginning in Novembe

The Committee extended its mandate beyond the drug abuse to include alcohol and licit pharmaceutic cember, 1986. Its hearings concluded in June, and its it learned — as well as its comments on the national — should be released this fall.

The witnesses the Committee called to Ottawa, an pear at hearings in Toronto, Victoria, Vancouver, a represent all areas of the addictions field: the leade agencies; experts in prevention, research, and tr resentatives of community groups; employee assis providers; and, both workers and former client centres.

The issues the witnesses brought to the Commit Committee responses and questions — offer a revie issues and concerns now facing the addictions field.

The Journal presents a synopsis of some of these not a complete list, but an indication of what the Co and what addictions experts wanted them to hear.

The Committee members are all members of Pa include: government (Progressive Conservative) m Bruce Halliday (chairman), Barry Turner (vice-ch Mantha, W. Paul McCrossan, and Brian White; She eral), and Howard McCurdy (New Democratic Party

Should there be a Canadian national institute?

Ann Kern, Department of Health, Government of Australia: "(In Australia) there is $1 million (budgeted) for two centres of excellence. One is . . . devoted to the service provision side, and the other is more to the research side. I believe you do it better in Canada. The Addiction Research Foundation (ARF) in Toronto is the right combination. I will argue until the day I die that in Australia we got it wrong."

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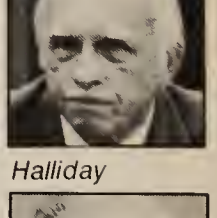
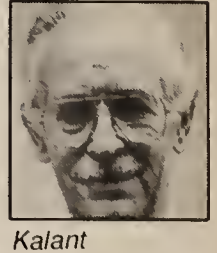
Mr Halliday: "Further to Ms Copps' question regarding the origin of ARF and the fact you have a concept of being a national institute in Canada, or not, should we be directing more federal funds, if it were possible, toward ARF?"



Halliday

Harold Kalant, MD, PhD, director, biobehavioral research, ARF: "The definition of a national institute is not an easy one. Many people . . . think of a building or a physical place where you gather people and have them work on a particular subject. In universities, institutes can be paper institutes . . . I think a national institute would be highly desirable, both as a recognition on the part of the federal government of the importance of the subject and to facilitate the kinds of development that are required to produce effective prevention and treatment methods. But, which type of institute it could be, whether it would be in a building in Ottawa or whether it could be a federal mechanism for facilitating the activities of groups all over the country who have something to contribute to it, is a decision for the government to make. I think either one could be beneficial."



Kalant

Do we need more research?

Mr Turner: "I am curious to know what kind of re doing today that ready done or dis lem has been lo tions now. . . . **Dr Kalant:** "... long-term invest target and achiev say, 'We will bui we have the te draw up a time are many things cal action of dru interactions mus courage, drug w of changing atti with respect to know."

What about amounts of to drug traffi

Chief Superin Stamler, direct ment Directorat Mounted Police finish with the n nized crime gr responsible for these drugs. The to the tune of m and billions of do ganized crime lieutenants will drug shipments do touch, they money from the fore, the investig or identify organ ity is to follow the money by tracing, freez ing, and seizing these proceeds Then you can identify the up per levels of or ganized crime They can be pros- ecuted. . . ."

What about of demand supply reduc

Mr Turner: "Ev Every time there other side of the mand. We don't over the supply are not great pro But, the demand cus on for a mu

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erintendent **Rodney** rector, Drug Enforce-orate, Royal Canadian lice (RCMP): "I will he need to attack orga- groups . . . primarily for the distribution of They are profiting . . . f millions and millions of dollars. . . . Most or-me leaders and their will not come near a nt. The one thing they ey do receive, is the the proceeds. There-estigation to eliminate organized crime activ-

Stamler

put the question nd reduction vs duction?

"You speak of supply. there is supply, on the of the equation is de- not have much control pply side, because we t producers in Canada. nand side I want to fo- a minute, particularly with young people. . . . We have to focus more on eliminating that part of it, through education and through . . . better treatment centres, and more of them, perhaps, and through better law enforcement."

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Mr Halliday: "Mr McKissock, although you can be proud your seizure statistics are going up, we have been told that any time a seizure is made, there is an automatic replacement of the same drug at no cost to the importer here in Canada. It does not matter how much you seize, it is going to be replaced . . . . Why should we worry about the supply side? Perhaps, we should be attacking the demand side."

McKissock

William McKissock, chief, narcotics section, Interdiction and Intelligence Division, Customs and Excise: "We are somewhat biased because our job is on the supply side. Our job is to stop these things. However, we do believe the seizures are causing problems to the traffickers. Yes, it is being replaced, but it is being replaced at a considerable cost as well. As I mentioned to you before, we do believe there has to be a balanced approach between supply and demand. I do not think you can look at the supply side separate from the demand issue, nor the other way around."

Are licit drugs as big a problem as illicits?

Howard Greenstein, executive director, Saskatchewan Alcohol and Drug Abuse Commission: "Yes. Alcohol is by far the drug most abused in this country. No question about it."

Mr McCurdy: "Even among adolescents."

Mr Greenstein: "Yes, as far as we know."

Mr McCurdy: "The notion is that adolescents are all out smoking pot, and, therefore, that is their major problem."

McCurdy

Mr Greenstein: "It tends to receive the most media attention. I think we also have to consider the fact alcohol is an accepted drug of use within this country and . . . alcohol use is in fact promoted very vigorously."

What about head shops?

Sergeant Mike Pelletier, drug prevention officer, RCMP: "A major concern to parents and youth, which we have addressed, expressed the need to outlaw paraphernalia sales. Simply stated, if it is illegal to use drugs, why can we promote the sale of the tools to use them? Over 30 states in the United States have implemented legislation to restrict and forbid the sale of such equipment."

•••

Mr Turner: "Head shops? How could I forget such a name? Should we make them illegal?"

Dr Kalant: "The objects they sell are all legal objects. What they do is contribute to the glamorization . . . of the drugs with which those objects are associated and used. The trouble is if you ban those, you really should ban movies and books and . . . ."

•••

Norm Panzica, counsellor: "We absolutely need a law . . . . The people who object most to the lawful sale of paraphernalia in my travels are high school kids . . . . (They) ask if this stuff is bad for you and using it is illegal, why are they selling hash pipes?"

Panzica

What prevention programs are needed?

Ms Copps: ". . . When you have been drinking for 20 years or whatever, sometimes it is a little too late. It is never too late; but, if you could move in at an earlier age and stage, it might be a lot more cost-effective, as well as effective for the individual."

Copps

Joseph MacIntyre, executive director, New Brunswick Alcohol and Drug Dependency Commission: "I couldn't agree with you more . . . . The average person, if I could take a profile, would be a person in his 30s."

MacIntyre

•••

Bill Graham, vice-president, CanCare Canada: "I do not think the youth should be regarded continually as the sole target for prevention programming. I think adults probably should be built in some place."

•••

Joan Marshman, PhD, president, ARF: "I think the recent experience around drinking-driving has given us some clues . . . . There is a very consistent message coming in drinking-driving, a message that is promoted even by the beverage-alcohol industry. . . . We just say, 'Do not drink and drive,' a very understandable message and a very consistent message and a message which focuses on the specific behavior."

Are street drugs purer today?

Staff Sergeant **Lawrence Hovey,** Metro Toronto Police: "A concern to us is the fact that the marijuana today is not the marijuana of yesterday. We have families who grew up during the 1960s and who are now parents and raising their own kids. The marijuana they were using at that time was home-grown, with 0.75% purity in the tetrahydrocannabinol . . . . Now, we're getting percentages of purity up to 7.9% pure THC content."

Can the provinces and the federal governments work together?

Mr Greenstein: "We are hopeful a partnership will emerge . . . . The history of federal-provincial cooperation in this field, through the federal-provincial subcommittee, has been quite positive. The recent change of this body to the status of an official federal-provincial advisory committee reflects the current interest of the federal, provincial, and territorial ministers of health."

•••

David Gilbert, executive director, alcohol and drug programs, British Columbia Ministry of Health: "I firmly believe the approach to doing something about substance abuse in Canada has to be carried out cooperatively between the three levels of government, including our colleagues at municipal levels. And, I would urge you (the Committee) to meet with your colleagues in the legislative assemblies."

Is more addictions training needed? For whom?

Marvin Burke, executive director, Nova Scotia Commission on Drug Dependency: "Physicians have to be trained. They have to be trained to understand this problem, to understand that there are many resources in the community that are prepared to work alongside them. It is very crucial that this not be considered just in our school (Dalhousie Medical School), but right across the country."

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Mr MacIntyre: "Canada is seen to be woefully lacking in the provision of adequate addiction treatment training, not only for persons currently working with people problems, but also for all students currently studying to become physicians, psychologists, and social workers."

•••

Donald Meeks, PhD, director, School for Addiction Studies, ARF: "There is a need for concerted action, for cooperation and collaboration among the various parts of our community — the family, the school, the workplace, the health and social services systems, law enforcement and judicial systems, correctional systems, and, I dare say, all levels of government. . . . There is a need to provide education and training to the personnel in these various systems."

Meeks

What should Canada be doing internationally?

Mr McCurdy: "I was interested in the statement . . . which implies that the effectiveness of the Canadian delegation was materially affected by the rapid turnover and inadequacy of staff in External Affairs. Would you elaborate on this please?"

Donald M. Smith, PhD, a former chairman, United Nations Commission on Narcotic Drugs: "My complaint is that I had to teach each of these dozen people each year what the whole thing is about. You see other countries come with their delegations that have been coming for years, so they know intimately the members of the other delegations — who is approachable, who can get your resolution through, etc. Well, put it this way: I was able to do it, but now that I am retired, who is going to be able to do it?"

Smith

The testimony of witnesses to the House of Commons Standing Committee on National Health and Welfare has been excerpted from minutes and proceedings of the Committee, October 1, 1986 to May 25, 1987.

• Concerns

Murray Elston, Ontario minister of health: "In terms of us getting federal money, that's going to be beneficial. But, we'd want the programs to tie in with what we've already done. They'd have to be cooperative in terms of what we want."

Joan Marshman, PhD, president, Ontario's Addiction Research Foundation (ARF): "I believe there should be an executive function located within the federal structure. . . . There should be an advisory structure to that executive function which will bring forward the expertise which exists in the provinces and the territories in the field. There should be what I will basically call an objective, peer-review approach to looking at the programs and projects that are available and making a selection of the best. . . . The other (committee) would be the multiple ministries of the federal government, which I would see more as policy advisory function."

Howard Greenstein, executive director, Saskatchewan Alcohol and Drug Abuse Commission: "We are concerned that the areas of agreement between our recent efforts and the national drug strategy have been in fact the most difficult areas to secure federal cost-sharing (for) in the past. We have been unable, for example, to obtain federal cost-sharing in our prevention and in our training efforts, nor will we be able to share the cost of public awareness activities or youth treatment under the current Vocational Rehabilitation of Disabled Persons (Act) interpretations."

Greg Stevens, chairman, Alberta Alcohol and Drug Abuse Commission: "We believe this is a unique opportunity in Canadian history to tackle the problems of addiction in a more concerted manner and on a truly national basis. . . . It is essential that the national drug strategy be based on sound health promotion principles. It should be broad in scope in order to address alcohol and tobacco issues and other drug concerns."

David Gilbert, executive director, alcohol and drug programs, Ministry of Health, British Columbia: "We cannot replicate what was done in the early 1970s, where the federal government established a commission, the LeDain commission, which went off and did its thing, laid all sorts of programs on the provinces, expected the provinces to pick them up when the funding dried up, and we were left kind of holding the baby. . . . It has to demonstrate a national strategy and not a federal strategy."

(continued on page S4)

• Who's who

The key players, nationally and provincially **pS4**

Canada's drug strategy

• Concerns

(from page S3)

Marvin Burke, executive director, Nova Scotia Commission on Drug Dependency: "We would hope, and Nova Scotia feels very strongly about this, that any programs that are mounted are long-term programs — five, 10, even 20 years — because very often, programs that are important take a year or two to get wound up. If you are given a three-year budget or setting a three-year term, or a five-year term even, no sooner have you wound up the project than you are getting ready to unwind. That is useless. People are going to be around for a long time, and the problem is going to be around for a long time."

Donald Smyth, drug education consultant, Ottawa Board of Education: "Let us not have the situation in 1987 where we see groups, well-intentioned, starting from scratch to develop a prevention or an intervention program that is not reflecting the research and that may take five or six years to perfect, when we could look at some programs that are working."

Henry Schankula, director, ARF education resources division: "There are areas of expertise which need to be united. I see a federation of centres of excellence, and I see it functioning as a national resource."

Karl Burden, executive director, Alcohol and Drug Concerns, Inc (ADC): "We and several agencies like ours are limited by available funds. So much of our effort has to be put into fundraising. We do not see ADC as benefitting 100% from federal money. That would be a dangerous development, but funds for specific and identifiable programs and activities would be of immense benefit to many."

• Who's who

TORONTO — Canada's national drug strategy is a federal program, but implementation of many of its components will fall to the provincial and territorial governments and their addictions agencies.

To understand how the implementation will work, it is important to know who the provincial and federal players are. **The Journal** *presents an outline below of the federal departments involved and their ministers, and the provincial and territorial addictions agencies and their chief executive officers.*

Federal

Health and Welfare Canada (H&W)
Health Minister Jake Epp
(lead minister)
Solicitor-General Canada
Solicitor-General James Kelleher
Revenue Canada (RC)
Revenue Minister Elmer MacKay
External Affairs Canada (EA)
External Affairs Minister Joe Clark
Justice Canada
Justice Minister Ray Hnatyshyn

Interdepartmental Secretariat on Drug Abuse
Barbara Darling, *executive director*
H. David Archibald, *senior adviser*

Delegation, International Conference on Drug Abuse and Illicit Trafficking (ICDAIT)
Health Minister Jake Epp
Maureen Law, *deputy minister, H&W*
His Excellency Jacques Gignac, *permanent representative to the international organizations at Vienna*
Robert Simmonds, *commissioner, Royal Canadian Mounted Police (RCMP)*
Alternates
Bruce Halliday, *chairman, standing committee, national health and welfare*
Albert Cooper, *member of parliament*
Nancy Clark Teed, *New Brunswick Health Minister*
Greg Stevens, *chairman, AADAC*
Advisers
The team of 15 advisers includes:
Barbara Darling
Jacques LeCavalier, *director, Bureau of Dangerous Drugs, Health Protection, H&W*
Franco D. Pillarella, *director, human rights and social affairs division, EA*
Chief Superintendent Rodney T. Stamler, *director, drug enforcement directorate, RCMP*
David Thornton, *director, health promotion programs, H&W*
Joan Marshman, *president, ARF*
Marvin Burke, *executive director, NSCDD*

Provincial

British Columbia
David Gilbert
executive director, alcohol and drug programs
Ministry of Health
Lead ministry: Health
James Dinning, minister

Alberta
Jan Skirrow
executive director
Alberta Alcoholism and Drug Abuse Commission (AADAC)
Lead ministry: Community and Occupational Health
Peter Dueck, minister

Saskatchewan
Howard Greenstein
executive director
Saskatchewan Alcohol and Drug Abuse Commission (SADAC)
Lead Ministry: Health
George McLeod, minister

Manitoba
Ian Puchlik
executive director
Alcoholism Foundation of Manitoba
Lead ministry: Health
L. L. Desjardins, minister

Ontario
Joan Marshman, PhD
president, Addiction Research Foundation (ARF)
Lead ministry: Health
Murray Elston, minister

Quebec
M. Claude Arsenault
chief, drug programs
Ministry of Health and Social Services
Lead ministry: Health, Social Services
Therese Lavoie Roux, minister

New Brunswick
Joseph MacIntyre
executive director
Alcoholism and Drug Dependency Commission
Lead ministry: Health
Nancy Clark Teed, minister
Nova Scotia
Marvin Burke
executive director
Nova Scotia Commission on Drug Dependency (NSCDD)
Lead ministry: Health, Social Services
Ronald Russell, minister
Prince Edward Island
Mark Triantafillou, MD
director
Addiction Services of PEI
Lead ministry: Health, Social Services
Keith Milligan, minister
Newfoundland
George Skinner
chairman
Alcoholism and Drug Dependency Commission of Newfoundland and Labrador
Lead ministry: Social Services
Charles R. C. Brett, minister
Yukon
Paul MacDonald
coordinator
Alcohol and Drug Services
Health and Human Resources
Lead ministry: Health, Human Resources
Margaret Joe, minister
Northwest Territories
Winnie Fraser-MacKay
coordinator
alcohol and drug services
Health and Social Service Programs
Lead ministry: Health, Social Services
Bruce McLaughlin, minister

Federal/provincial sub-committee on alcohol, drug problems

George Skinner, *Nfld*
Mark Triantafillou, *PEI*
Marvin Burke, *NS*
Joseph MacIntyre, *NB*
M. Claude Arsenault, *Que*
Joan Marshman, *Ont*
Ian Puchlik, *Man*
Howard Greenstein, *Sask*
Jan Skirrow, *Alta*
David Gilbert, *BC*
Paul MacDonald, *Yk*
Winnie Fraser-MacKay, *NWT*
Lavada Pinder, H&W
John A Conley, H&W

• World stage

By Gamini Seneviratne

VIENNA — On the eve of the International Conference on Drug Abuse and Illicit Trafficking (ICDAIT) here Tamar Oppenheimer, conference secretary-general, talked to journalists.

"I think it is important to put the more superficial elements, who comes and who says what, into the context of what the United Nations is trying to do by summoning a conference of this type."

Mrs Oppenheimer also said:

• "I do *not* share the view that this problem has arisen owing to a greater availability of drugs. I would like to put this into the context of *basic economics*. Availability arises from a market, from demand.

• "Wherever there is a market, and demand occurs, the supply will rise, not only to meet existing demand but also to endeavor to expand the market. This is the more obvious because . . . in the market, being illicit, there are no trade organizations which estimate, for the producers, what the market will bear.

• "We ourselves, in the trade if you will, do not know the extent of the market. This is one of the most undocumented problems that exists in the world today.

• "We do not know what the demand is; neither do the producers — whether they grow the drugs, whether they process the natural products into drugs, or whether they manufacture man-made drugs, the psychotropic substances.

• "Consequently, there is a tremendous overproduction . . . . There is, in consequence, a great deal of competition — between the illicit producers and distributors — to market and to develop markets for their products.

• "Unless we look at this from the point of view of an economic problem, we risk a distortion of our perception, of how we should go about dealing with the problem as a whole. It is, of course, necessary to control supply, to interdict the illicit traffic which is in effect a very simple enabling device of a distribution mechanism.

• "What this conference is focusing on is an enlargement of the international community's perception — beyond supply control, beyond illicit trafficking, to deal with the problems of *demand* reduction.

• "What we specifically need for this is an understanding of where the market is, where the demand is coming from, and where it is likely to be going. We know very little about this.

• "One of the things we hope the conference will get moving is to study the etiology of drug abuse because in order to make national policies, governments need to know the size of the problem.

• "The other area the international community will be dealing with, as a result of the great expansion of drug abuse and drug trafficking, is the question of how to treat, how to handle, how to rehabilitate drug abusers and drug addicts.

• "This is a matter which has been dealt with in a sporadic and piecemeal fashion in various communities. As with any other form of epidemic, the cures multiply, the proponents of these cures tend to become completely absorbed in their convictions as to the validity of their own techniques.

• "It is perfectly clear that, as we are not well aware of the reasons for the demand, it is very difficult to treat the disease. It is necessary to place the techniques for treatment and rehabilitation into the context of the society and the community and into the context of the available resources of the community.

• "The problem is compounded by other developments in our societies, among them, of course, the recently burgeoning epidemic of AIDS. The inter-link between AIDS and drug abuse poses additional problems, not only for the spread of the two epidemics but also to the health and treatment resources of every community and every member state."

The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1

INTERNATIONAL

Field-test kits a boon to drug-trafficking fight

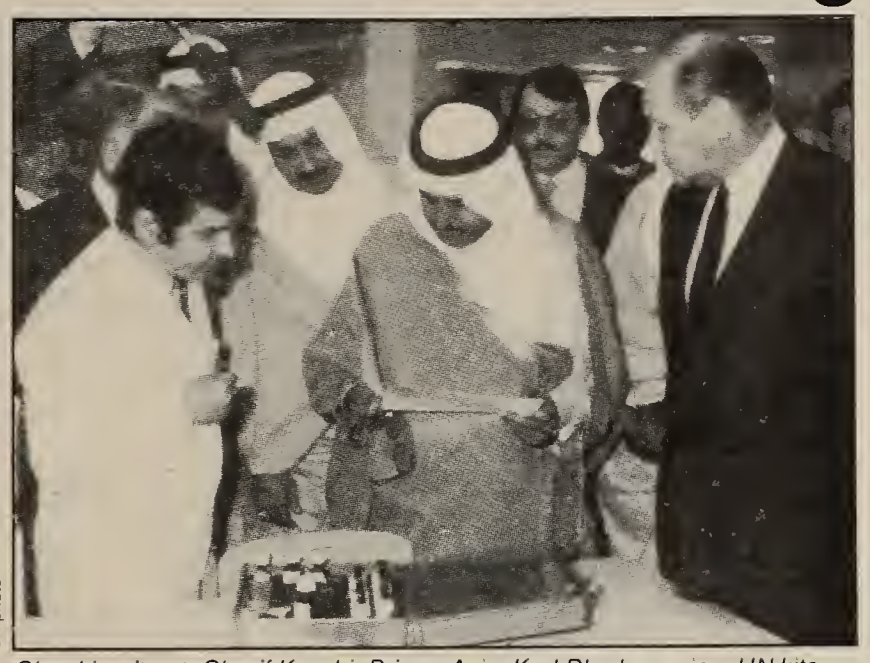
By Gamini Seneviratne

VIENNA — Chemists and forensic scientists from six countries met here on the eve of the ministerial-level International Conference on Drug Abuse and Illicit Trafficking (see page S4) and agreed rapid-test kits to detect drugs of abuse are essential tools, despite their limitations.

The rationale for portable kits is a mix of human rights and law-enforcement efficiency: if cops on the street and Customs officers in remote stations can use them properly, nobody need be detained for long just because they're carrying a substance that looks like a contraband drug.

Law officers can confirm or dismiss suspicions in a matter of minutes via a simple desktop or street-corner assay.

The experts here suggest such rapid, field-test capability is essential for a long list of most trafficked controlled substances, as well as for several precursors used in the illicit synthesis of drugs.



UN photo

Checking it out: Cherif Koudri, Prince Aziz, Karl Blecha review UN kits

After examining a range of available field testing kits, the scientists selected 20 tests. Simplicity and speed were the decisive factors for the selection.

For some drug groups and precursor chemicals, no field kits are yet available; and, the specificity of some existing kits needs to be improved.

All kits have built-in limitations, the experts agree. For example, the chemical structures of controlled and uncontrolled drugs are very much alike, while the quick field-test methods work mostly on color tests which are at best group-specific and cannot distinguish between more than a few basic colors.

Also, there are increasing limitations on usable chemicals because they just might cause cancers or could be explosive.

The experts advise testing suspect substances twice, by different chemical routes, in a logical sequence. If the testing needed is beyond the capacity of the labs, the scientists say samples should be sent to authorized laboratories.

On user safety, given that there was no way concentrated chemicals could be avoided, they urge clear warnings and instructions, proper training and the inclusion of neutralizers in the packs.

The Vienna meeting, financed by the Austrian government, was held under the aegis of the UN Division of Narcotic Drugs (DND). Not surprisingly, the kit most carefully scrutinized was the one completed three years ago by DND chemists and technicians. This is a versatile package, the first capable of spotting methaqualone and still one of the few able to detect crack. It can be used on about 100 controlled substances and is very simple to use.

What clearly amazed the experts from Argentina, Austria, West Germany, Japan, and the Netherlands, with a senior US official sitting in as a DND consultant, was that the DND had neither forward assurance of training nor feedback on performance from recipient countries.

This situation, they said, must be remedied. They asked the UN to do three things — seek formal agreements with governments to ensure national training, give consideration to sending a staffer to train trainers in countries that ask for large supplies of the kit, and generate feedback, on both performance and training, via a questionnaire to accompany each shipment.

Beer ads' macho image slammed

By Pat McCarthy

AUCKLAND, NZ — Abuse of alcohol has been criticized by a New Zealand government committee of inquiry into violence.

The committee's recommendations contradict those of a government-appointed working party on liquor licensing law.

"The causal link between alcohol and violent offending is established beyond any doubt, although the causal pathways may be complex and difficult to determine," the committee reports.

The committee particularly condemns the image of the "good Kiwi bloke," who drinks hard and plays tough.

Criticisms of the damaging effects of this macho figure, parading across television screens and sports fields, provide a continuous thread running through the report.

Liquor advertising receives special censure, particularly the link frequently made between alcohol and sport which, the committee says, is still "the most potent symbol of masculinity for many New Zealand men."

One beer advertisement with the slogan, "The measure of a man's thirst" — suggesting that sporting ability, determination, and drinking a particular brand of beer are hallmarks of a man — is described as "arrant nonsense."

Recommending that beer advertising steer away from presenting a macho image to drinkers, the committee says: "The aim should be to sell beer, not fantasies."

Clashing with the proposals of the working party on licensing law — whose views alarmed agencies concerned with alcohol abuse (The Journal, May) — the committee on violence firmly opposes Sunday trading, lowering the drinking age to 18 years from 20, and allowing supermarkets to sell liquor.

On licensing hours, the committee says: "What change is required, if change is to be made, is a reduction in the drinking hours, and certainly not an extension

The committee, chaired by a retired High Court judge, also recommends smaller hotel bars.

"Large, crowded bars are almost impossible to supervise, and experience has shown that they are frequently the scenes of violence."

Another recommendation is for bars to close from 2 pm to 4 pm.

By directly countering proposals of the Government's working party, the committee on violence has presented legislators with a dilemma. Since this is an election year, the sensitive issue of reforming the country's liquor laws seems likely to be delayed until 1988.

Golobtsh

Ad suggestion: sell beer, not fantasies

INSIDE OUT

A question of courage

I was back 'home' again visiting a friend, back at the clinic where I had been more than a couple of years earlier, and we were in her office, catching up on things.

I had a lot to say to her — my life was taking a sharp turn once again, on a much different highway, and usually, although there was never any pattern to it, I'd felt a need to tell my friend about these changes, as if to seek her seal of approval and get encouragement to stick with it.

It was a little like going to a teacher to tell her of your academic progress, and it provided some continuity in my life because it was a way of showing somebody: 'See, I'm still here, still alive, still trying to make you feel good about me.' It was a way to touch ground when some of my flights became too crazy.

(I used to wonder, sometimes, after I'd say my goodbyes to her at these meetings, how many others who had been in the clinic had had this same desire to keep going back to the scene of the crime, as it were. For me, it had become a little ritual, a talisman, a trigger for memories that were full of healing and hopefulness. It was a refuge where I had had the astounding prospect, for the first time since I was a child, of experiencing — there are no other words — a wondrous sensation of purity.)

So, we babbled on and laughed; then I noticed another woman in the office standing away from my friend's desk. Was she a new counsellor, I wondered. I'd never seen her before and I suddenly felt a little shy.

Then my friend introduced us. The woman was in the clinic as a patient — a 'client,' I guess they call it, a dreadful word indeed — and she looked afraid and tentative and awfully alone.

Telling me things about themselves that so eerily echoed my own experiences as a child

We began chatting; how's it going, blah, blah, blah, the usual awkward exploratory stuff of first meetings. But, beyond my initial sense of compassion for her, the truth is, I was so glad I wasn't in her situation: I was happy, smug, that I'd already 'graduated' from the clinic.

Yes, I felt like somebody who'd gone through tough commando training. And now, here I was, looking into the face of a scared recruit, and say, isn't it amazing how easy it is to feel superior to other people. And why is it always the weakest who feel that way the most?

Then it was mentioned that the woman had been to an Adult Children of Alcoholics (ACA) meeting at the clinic, and, inside, I instantly froze up and any feeling of false superiority went away immediately.

I remembered ACA very well. It is a recently formed movement, spreading now like a brush fire around the continent, that's trying to break down the denial and shame that still echoes in the lives of people who have grown up in alcoholic families. It uses as one of its linchpins the principles of Alcoholics Anonymous.

Its motto is 'Adopt yourself'; it's trying to break the chain of victims raising victims.

I had gone to my first ACA meeting in the guise of an interested, yet neutral, observer, and the proceedings finished with me torn in a dozen different places.

I hadn't been prepared for the shattering expressions of sorrow and fear; I wasn't expecting to hear people I didn't know telling me things about themselves that so eerily echoed my own experiences as a child and as a man and as an alcoholic.

The meeting was so overwhelming that I only went to one other after it, and that was it. Some horrors are best left buried, I believed.

My brief experience with ACA had been almost more draining than coming to grips with my addiction and trying to live with and shakily, one day at a time, transcend it.

I told my counsellor friend and the other woman about this, and then I looked again into the woman's still scared face and suddenly I knew that if she could go and face up to both the clinic and the firepower of ACA, then perhaps she had more courage than I had.

A little later, when the counsellor told me some of the woman's background and the truly unbelievable horrors of her growing up and of her present situation, I felt very badly about myself and wondered just how much 'progress' I had really been making.

So, I went with the woman to the next ACA meeting; we sat next to each other, we listened to the tears and the anguish, the real pain, a few floors away from the clinic (she had one week left before she had to go outside again and pick up the pieces). At the end of the meeting we held hands, and I silently prayed for her to make it, to hold on, to be good to herself, and not to be afraid any longer.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

HOWELL

Sketches from a dark palette

It may have been a box-office bomb, but the movie *Head Office* does have a few good moments.

One of them comes when John Kapelos (playing the role of General Seputeda, head of the Ruling Democratic Party of the fictional republic of San Marcos) enlightens Judge Reinhold (playing the role of a United States multi-national executive) on the differences between the First World and the Third: "You Americans think you can buy us like that, huh, you and your self-righteous democracy.

"You have democracy, my little friend, because you are rich, huh, you are rich because you can afford both the Mercedes and the Free Press, huh. We in San Marco are poor, Señor, we can afford only one: the Mercedes. Heh, heh, heh, heh!"

I like that little speech. It resonates on more than one frequency. It puts things in perspective. For instance, recently a spokesman for the Bolivian government was quoted in Europe as saying that US $300 million would buy eradication of 60,000 of the 70,000 hectares in Bolivia currently devoted to coca-bush cultivation.

You pay your $300 million, you wipe out 60,000 hectares, just leaving enough to supply the needs of domestic coca-leaf chewers — as agreed to in the 1983 treaty between Bolivia and the US — that takes care of the cocaine problem, right?

Unless, of course there really are, as some experts estimate, as many as 200,000 hectares under cultivation. That would leave 130,000 hectares capable of supplying the Miami, Florida wholesale market with approximately $4 billion worth of cocaine annually. Not enough to buy a free press maybe, but enough to keep someone (guess who) well-stocked with Mercedes cars. Heh, heh, heh, heh.

As I said, I like that little speech. It resonates. Consider this: the Bolivian government spokesman said that Operation Blast Furnace, a combined US and Bolivian para-military operation against coca-producers, had put the drug gangs in retreat by driving coca prices so low many growers were looking for alternatives.

But, approximately at the same time as this rosy picture was being painted, former US Air Force Major Clarence Merwin, the commander of Operation Blast Furnace, was providing sketches from a much darker palette.

One such sketch emerges as a Columbia Broadcasting System (CBS) newsmagazine interview with reporter Jane Wallace, an interview that was never broadcast. An article in the May, 1987 issue of *The Atlantic* by David Kline, co-producer of the interview, says it went like this:

Wallace: You had eight different commanders?

Merwin: Eight. It was mostly because they either got too blatant about accepting bribes, or, in the case of the only really good tactical field commander we had, he refused to take a bribe and he got fired by the boss, who had offered him the bribe.

Wallace: Is (the current director of the Narcotics Police) on the take?

Merwin: . . . If this one isn't, his predecessors all were.

Wallace: All of them?

Merwin: To my knowledge, all of them.

Wallace: In what ways?

Merwin: New cars. Send your kids to the States to go to school. One of the former Leopard commanders who was dishonest — he was bad when we got him, and he got worse — I understand that he now has a really nice ranch. Has a new BMW. Wears really nice clothes . . . .

Wallace: And the rest of the enforcement structure in Bolivia . . . how corrupted was that structure?

Merwin: I have to tell you I think that 100% of the Bolivian enforcement structure was corrupted.

Operation Blast Furnace involved 160 US soldiers and para-military operatives ferrying Bolivian Leopards (Bolivian Drug Police in UMOPAR, the Mobile Rural Patrol Unit created subsequent to the August, 1983 treaty) to raids on 256 suspected cocaine laboratories.

The result: the men under Maj Merwin's command seized and destroyed 22 *empty* labs and did not arrest one trafficker. The only time they came close was when Maj Merwin, in desperation, thought up his own version of 'heh, heh, heh, heh.'

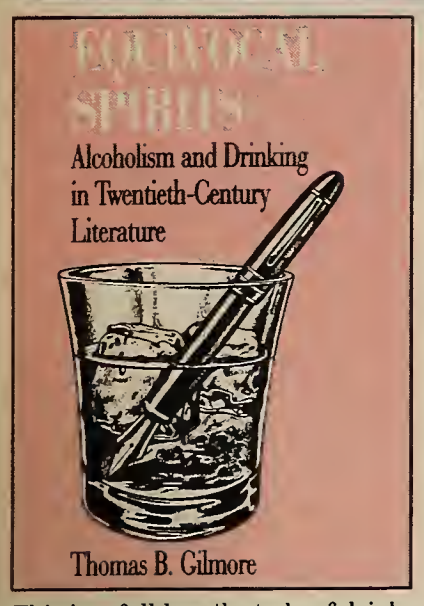
One time, he launched a raid on a lab in Beni province but did not inform La Paz of the raid until he was airborne. Taking no chances, he did not inform the air crew where they were going until they had been in the air 20 minutes. That time, the Leopards found a working cocaine lab stocked with 210 kilograms of cocaine and surprised the owner of the operation as he was having lunch. But, the owner was having lunch with a Bolivian senator; two days later, he was released from jail on orders of the Bolivian government. Heh, heh, heh, heh.

By Wayne Howell

REVIEWS

New Books

by Margy Chan*



This is a full-length study of drinking as it is depicted in literature, both by writers who have had drinking problems and those who have not.

It examines the works of Malcolm Lowry, Evelyn Waugh, Eugene O'Neill, John Cheever, Saul Bellow, F. Scott Fitzgerald, John Berryman, Kingsley Amis, and George Orwell.

The author demonstrates that literature can better convey the complex struggle experienced by alcoholics. The perspective of science on alcoholism is almost always the same: diagnostic, analytical, and objective, whereas the perspectives of literature are varied.


Gilmore

University of North Carolina Press, Chapel Hill, North Carolina. 1987. 226 p. $9.95 (paper), ISBN 0-8078-4174-9. $22.50 (cloth), ISBN 0-8078-1726-0.

Genetic and Perinatal Effects of Abused Substances

. . . edited by Monique C. Braude and Arthur M. Zimmerman

This book reflects current scientific knowledge of the genetic and perinatal effects of abused substances. It provides an overview of the field and assesses the actions of drugs such as opiates, cannabinoids, nicotine, and ethanol.

It will be of interest to clinicians, cell biologists, physiologists, and toxicologists interested in drug abuse.

Harcourt Brace Jovanovich Canada, Don Mills, Ontario. 1987. 211 p. ISBN 012126002X.

EAPs and the Information Revolution: The Dark Side of Megatrends

. . . by Keith McClellan and Richard E. Miller (ed)

The information revolution has resulted in changing economic and occupational trends. This special issue of the *Employee Assistance Quarterly* (vol 2 no 2) is devoted to looking at the negative impact of these changes on workers' health and well-being.

Experts in the employee assistance program field examine the issues and seek new treatment approaches to help workers cope with problems such as displacement, disruption of social norms and lifestyles, emergence of new occupational ailments, increased invasion of privacy, and diminished health care.

Haworth Press, Inc. New York, New York. 1987. 106 p. $22.95. ISBN 0-86656-606-6.

. . . by Boris M. Segal

This is a comprehensive history of the origins of heavy drinking and alcoholism in pre-revolutionary Russia. The author is a Russian emigré and one of the foremost authorities on alcoholism in the USSR. He draws on worldwide sources in medicine, psychiatry, psychology, literature, and history to provide perspectives and better understanding of Russian behavior and culture.

Many important topics reviewed are completely unknown to most Western readers: Tsarist alcohol policy, role of Russian religious and secular ceremonies, drinking establishments, drinking styles of various social and ethnic groups in the USSR, drinking by women and teenagers, the per capita consumption of alcohol, and the incidence of alcoholism and its impact on crime, accidents, and suicide. The problems of research, treatment, and prevention of alcoholism in pre-revolutionary Russia are discussed.

Rutgers Centre of Alcohol Studies, Piscataway, New Jersey. 1987. 383 p. $29.95 (cloth), ISBN 911290-18-4. $19.95 (paper), ISBN 911290-19-2.

The Pharmacologic Treatment of Tobacco Dependence: Proceedings of the World Congress

. . . edited by J.K. Ockene

This comprehensive examination of the use of drug therapies to treat tobacco dependence contains papers and discussions from the World Congress, held in New York city November 4-5, 1985. The Congress brought together researchers and scientists from all over the world to discuss new approaches to treating smoking.

The Congress was part of an ongoing series begun by the Institute for the Study of Smoking Behavior and Policy at Harvard University, Cambridge, Massachusetts. The Institute hopes the series will not only educate and inform about the state of today's knowledge, but also will help guide future actions, attitudes, and policies in the pharmacologic treatment of tobacco dependence.

Institute for the Study of Smoking Behavior and Policy, Cambridge, Massachusetts. 1986. 302 p. $10.

Books received

Stage II Recovery: Life Beyond Addiction — Earnie Larsen. San Francisco, California. Harper & Row. 1985. 101 p. $5.95. ISBN 0-86683-460-5.

Rusmiddelforskning i Danmark efter 1980: en forskningsoversigt (Substance Research in Denmark after 1980: A Research Review) — edited by Jørgen Lund and Kirsten Nielsen. Danish Council on Alcohol and Narcotics, Copenhagen, Denmark. 1980. 56(150)p. Council on Alcohol and Narcotics Publication Series; no 9. ISBN 87-88285-44-8.

Living with Drugs — Michael Gossop. Second edition. Wildwood House, Aldershot, England. 1987. 242 p. £5.95 (paper). ISBN 0-7045-05665.

** Margy Chan is manager of the Addiction Research Foundation's library, the leading library in the field worldwide. A graduate of the University of Hong Kong, she holds a master's in library science from the University of Toronto.*

ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Why Say No to Drugs

Number: 763.
Subject heading: Drugs and youth.
Time: 16 min.
Synopsis: Messages about drugs are all around us. Young people have to decide what they will do when offered any drug. The effects of cigarettes, alcohol, and marijuana are shown; techniques for saying no are illustrated. Young students explain what they think about using drugs; older students reinforce that it is acceptable to say no and that drug use is a personal decision.
General evaluation: Very good (5.2). This contemporary, well-produced film uses excellent visual effects. Role modelling of saying no is effectively portrayed. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit eight to 12 year olds.

Cocaine and the Student Athlete

Number: 768.
Subject heading: Cocaine, sports.
Time: 40 min.
Synopsis: There are millions of cocaine users in the United States. Purer (stronger) cocaine has become available, and crack use has become a problem. There is pressure on student athletes today because of potential financial rewards. Some athletes use cocaine to give them that extra edge and to cope with the natural depression that follows the 'high' of strenuous athletic endeavor. Professional athletes relate how they feel about drug use. Student athletes are urged not to use drugs. If they are already using, they are urged to seek advice from their coaches.
General evaluation: Poor (2.2). This film is boring.
Recommended use: The film is intended for high school and college athletes.

Alcohol, Drugs and Seniors: Tarnished Dreams

Number: 786.
Subject heading: Drugs and seniors.
Time: 23 min.
Synopsis: John Astin narrates this film about the good life seniors can have and the traumas — like retirement, loss of a spouse, and lessening capabilities — that can affect them. Some seniors use too many pills, even those prescribed by a doctor; others turn to alcohol to help ease the pain. Combining alcohol with pills is even more serious. Seniors recount their stories and how they feel after getting help.
General evaluation: Fair to good (3.6). The film has good information for seniors and their families. It could lead to good discussion about the wise use of alcohol and other drugs in the later years. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit seniors and their families.

Future Wave

Number: 790.
Subject heading: Smoking.
Time: 29 min.
Synopsis: A group of teenagers produce a film on smoking. They open with a girl walking through a mall watching smokers and nonsmokers; she meets friends and succumbs to pressure to smoke. Interviews deal with why people start to smoke, why they quit, and why they continue. A new girl at school wonders how to make friends. A boy tries to persuade her to smoke a cigarette; the same scene is replayed several times using different pressure and refusal techniques. Finally, another girl is transported into the future where she astounds everyone by lighting a cigarette. Scientists test the cigarette and tell her it is dangerous to her health.
General evaluation: Very good (5.1). This contemporary, well-produced film deals humorously with many smoking issues. Its lively pace, acting, and music are particularly effective. The film's creative portrayal of refusal techniques is well done and could lead to good discussion. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit those eight to 18 years of age.

Sex, Drugs, and AIDS

Number: 791.
Subject heading: Lifestyle.
Time: 18 min.
Synopsis: Rae Dawn Chong narrates this film on the association between AIDS, sex, and drugs. She attempts to dispel some of the myths about how one contracts AIDS and emphasizes that AIDS is hard to get. She stresses, however, that it can be contracted through unsafe sex and through the sharing of needles for drug use. Three girls discuss whether they should have sex with their boyfriends, and, if they decide to, how to tactfully insist on the use of condoms. Ms Chong identifies and strongly cautions four high-risk groups. AIDS patients tell how they contracted the disease; one man tells the story of his brother who recently died from AIDS.
General evaluation: Excellent (5.7). This well-produced film includes excellent information on the subject. It could lead to good discussion and perhaps help people avoid the disease. General broadcast is recommended.
Recommended use: With a resource person, the film would benefit those 15 years and older.

Alcohol: The Social Drug, Personal Problem

Number: 758.
Subject heading: Youth and alcohol.
Details: Four, 10-min filmstrips with audiotapes.
Synopsis: The filmstrips illustrate the path alcohol takes in the body. An historical perspective on the use of alcohol is provided. Several young people talk about the reasons for drinking or not drinking, and the narrator stresses everyone must make a personal choice.
General evaluation: Poor to fair (2.5). Some good information is presented, but the poor visuals detract from the overall impact, as do the assumptions everyone drinks and the erroneous statement Prohibition did not work.
Recommended use: With a resource person, the filmstrips could be used with young people between 12 and 18 years old.

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Canada

International Association of Forensic Sciences 11th Meeting — Aug 2-7, Vancouver, British Columbia. Information: International Association of Forensic Sciences, 801-750 Jervis St, Vancouver, BC V6E 2A9.

5th Annual Current Issues in Chemical Dependcncy Summer School — Aug 17-20, Winnipeg, Manitoba. Information: Noreen Kumlin, Rm 541, University Centre, University of Manitoba, Winnipeg, MB R3T 2N2.

Canadian Psychiatric Association Annual Meeting: The Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

Pharmacology and Drug Abuse Distance Education Course — September 16-December 16, January 20-April 20, 1988. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

1987 Criminal Justice Congress — Sept 27-Oct 1, Toronto, Ontario. Information: Congress 87 organizing committee, 60 St Clair Ave E, Ste 600, Toronto, ON M4T 1N5.

Health Promotion: Insights and Innovations — Oct 1, Toronto, Ontario. Information: Alison Stirling, Parkdale Community Health Centre, 1257 Queen St W, Toronto, ON M6K 1L5.

16th Annual Ontario Occupational Health Nurses Conference: Capital Gains — October 19-23, Ottawa, Ontario. Information: Barbara Taylor, 1116 Castle Hill Dr, Ottawa, ON K2C 2A8.

Input 87, 7th Biennial Educational Symposium on Employee Assistance Programs in the Workplace: Networking and New Perspectives — Oct 25-28, Ottawa, Ontario. Information: Input 87, conference and seminar services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

Drug Education Coordinating Committee 1987 Conference, Drug Abuse: Epidemic or Smokescreen — October 29-30, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

United States

US/Mexico Conference on Alcohol Related Issues — July 23-25, Los Angeles, California. Information: Beatriz Solis, conference coordinator, University of California, Los Angeles, Spanish Speaking Mental Health Research Center, Los Angeles, CA 90024.

10th Annual North Carolina School for Alcohol and Drug Studies — Aug 2-7, Wilmington, North Carolina. Information: Office of special programs, University of North Carolina Wilmington, 601 College Rd, Wilmington, NC 28403-3297.

American Hospital Association Annual Meeting — Aug 3-5, Philadelphia, Pennsylvania. Information: John A. McMahon, president, 840 N Lake Shore Dr, Chicago, Illinois.

North American Congress on Employee Assistance Programs — Aug 10-13, Seattle, Washington. Information: NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, Michigan 48084.

National Conference on Chemical Dependency in the Dental Profession — Aug 31-Sept 1, Chicago, Illinois. Information: Bill Oberg, American Dental Association, 211 E Chicago Ave, Chicago, IL 60611.

United States National Woman's Christian Temperance Union Annual Meeting — Sept 3-7, Camp Hill, Pennsylvania. Information: Mrs K. Edgar, president, 1730 Chicago Ave, Evanston, Illinois.

38th National Conference on Alcohol and Drug Problems — Sept 20-23, St Louis, Missouri. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St, #181, Washington, DC 20001.

National Association of Lesbian and Gay Alcoholism Professionals 2nd National Conference — Sept 24-27, Chicago, Illinois. Information: NALGAP, 1208 E State Blvd, Ft Wayne, Indiana 46805.

American Association for Automotive Medicine Annual Meeting — Sept 27-29, New Orleans, Louisiana. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Oct 3-7, Chicago, Illinois. Information: Thomas J. Delaney, executive director, ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

10th Annual Current Concerns in Adolescent Medicine — October 8-9, New York, NY. Information: Ann J. Boehme, associate director for continuing education, Schneider Children's Hospital, Long Island Jewish Medical Center, New Hyde Park, NY 11042.

American Medical Association National Conference on the Impaired Health Professional — Oct 8-11, Chicago, Illinois. Information: Janice J. Robertson, AMA dept of substance abuse, 535 N Dearborn St, Chicago, IL 60610.

American Public Health Association Annual Meeting — Oct 18-22, New Orleans, Louisiana. Information: William McBeath, 1015 15th St NW, Washington, DC 20005.

Family Therapy Works: 45th AAMFT Annual Conference— October 29-November 1, Chicago, Illinois. Information: American Association for Marriage and Family Therapy, 1717 St, NW Ste 407, Washington, DC 20006.

Association for the Advancement of Behavior Therapy Annual Meeting — Nov 12-15, Boston, Massachusetts. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

Abroad

International Conference on Drug Addiction: A Multidisciplinary Analysis — Sept 7-11, San Sebastian, Vitoria, and Bilbao, Spain. Information: Secretaria del II Congreso Mundial Vasco, Paseo de la Senda, 15-bajo, 01007 Vitoria-Gasteiz, Basque Country, Spain.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Secretariat, 6th World Conference on Smoking and Health, c/o Japan Convention Services Inc, Nippon Press Centre Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.

9th International Conference of the Non-Governmental Organizations for the Prevention of Drug and Substance Abuse — November 23-27, Hong Kong. Information: Conference secretary, 9th NGO Conference, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

Drug-free: Winter Olympics' challenge to athletes

Testing Olympic athletes: Calgary's new drug lab ready for starter's signal

By Margaret McCaffrey

CALGARY — While newspapers here report the upward spiralling of costs to the city of hosting the XV Winter Olympic Games next February, toxicologists at Foothills Hospital are gleefully playing with state-of-the-art equipment in their new, $2-million, drug-testing laboratory.

Funded by the Olympic organizing committee — the Olympiques Calgary Olympics (OCO) — the lab will be the testing site for all medal winners and for random spot checks of athletes at the Games.

Now awaiting accreditation as the second sports drug-testing laboratory in Canada (the other is in Montreal), the lab will be used after the Games for patient services, clinical toxicology research, pharmacokinetic studies, and sports medicine.

Bruce Challis, MD, chairman, department of family medicine, University of Calgary, and chief medical officer for the XV Winter Games, served as a medical officer at the 1984 Summer Olympics in Los Angeles, California, and the (1984) Winter Olympics in Sarajevo, Yugoslavia.

He's seen athletes stripped of their medals for taking drugs, but considers it's unlikely to happen in Calgary: "There are fewer weight-dependent sports in the Winter Games. In Los Angeles, there were 10,000 athletes and maybe 12 to 14 positive tests. In Sarajevo, there was only one."

At this level of competition, he told **The Journal**, "very few athletes haven't faced testing, and there are very few national sports federations without regulations against doping. Most athletes don't take the risk — it's too important to them."

Drug testing was first ordered by the International Olympic Medical Commission (IOMC) in 1967, after some athletes died from the effects of drugs. Now, testing looks for drugs which might give unfair advantage, risk of injury, or overall adverse effect on health.

Five broad groups of drugs are banned in competition: stimulants, narcotics, beta blockers, diuretics, and steroids, plus "related compounds" which would cover anything similar that hasn't yet turned up on testing, or which might be invented in the future.

It's fairly obvious what kind of an edge stimulants might give in competition, but narcotics? "They might mask the pain of an injury, give a euphoric high, or increase aggression," suggests Dr Challis. Beta blockers (see page 3), on the other hand, might have a calming effect and may reduce tremor, "which would be handy for compulsory figure skating."

Diuretics can produce instant weight loss or might dilute the urine so that other compounds might not show up. Dr Challis: "They test the urine pH and specific gravity. If it's low, they test for diuretic use."

Steroids build body muscle mass, but are usually taken in two months-on, two months-off cycles. It's possible for an athlete to have used steroids before the competition without it showing up on tests. The most common injectable kind will show up if taken within eight months of testing.

However, Dr Challis notes: "It's the policy of Sports Medicine Canada to test during training, and it's becoming policy in other countries too. The IOMC can sanction the trainer, the coach, and the physician as well as, or in lieu of, the athlete."

Inadvertent drug use is possible and has occurred when athletes have taken medication for allergies. "There's technically no reason for athletes to be taking a banned drug — there's always an acceptable alternative," says Dr Challis.

"If I were the physician for an athlete, I'd contact the nearest IOMC-accredited lab for a list of the acceptable drugs. We need to make athletes aware of this."

The most bizarre case Dr Challis has encountered occurred in Los Angeles, when several athletes were found to have taken ephedrine, a forbidden stimulant. On investigation, it was traced to an herbal tea they had drunk; no sanctions were taken.

Has an athlete ever been doped unwittingly, as in "nobbling" a racehorse? Dr Chalis has never encountered a case, but says it would be for the IOMC to decide if the athlete could not account for the presence of the drug in his or her urine.

Siu C. Chan, PhD, is the clinical toxicologist in charge of the drug-testing lab at Foothills Hospital. He set up the lab from scratch, having been lured from his job as chief toxicologist for the British Columbia Coroner's Service last year. His position with the Foothills lab is permanent; the lab also has OCO funds for three temporary staffers until the Games are over.

Dr Chan is excited by the chance to build a world class facility: "The profile of drug testing labs is very high right now, so what we do is being scrutinized internationally, which makes it very challenging. We're establishing a network of international cooperation; someone from Auckland, New Zealand, is coming to work with us for a month because they will be hosting the 1990 Commonwealth Games and they want to see how it's done."

During the Games, the lab will handle about 430 athletes' urine specimens. The samples will be collected at the site in front of an Olympic official, sealed in two containers, and transported to the lab where an IOMC official will be on duty. Bottle A will go for testing, Bottle B will be left with the IOMC official.

If any of the A samples look suspicious, they will be retested by mass spectrometry (**The Journal**, May). "This will give us the absolute identity of the drug," Dr Chan told **The Journal**. "If the test is still positive, we will run it one more time and then will tell the IOMC official present that it's positive."

The athletes will be informed, so that they and their representatives can be present when Bottle B is tested; if the test is positive, the athlete is called before the International Olympic Committee and asked to present his case. The IOC can then take whatever action it deems necessary.

To build up the necessary expertise for the task, Dr Chan and his staff have had to obtain samples of each banned drug and test for the compounds and their metabolites. Drug companies have obliged with samples of the drugs, but the metabolites are "almost impossible to come by." Thus, the lab staff have taken the drugs themselves and tested their own urine. They're now refining procedures in readiness for the Games.

Is it possible they'll find something they can't identify? Dr Chan: "We could find something new, in which case we'd study it for future reference. Perhaps, it will turn up on the banned list next time around."

Their worst fear? "A mass power failure, or perhaps an instrument failure. We'll have a service engineer in the hospital around the clock, and we have duplicate instruments. The worst it would do is lengthen turnaround time."

They want to have results in 24 hours — 48 at most if the test is positive.

What have they gained? "We have state-of-the-art equipment which we can use to test for any therapeutic or illicit drug. The instruments are very powerful, and the expertise we've gained will be used in our toxicology research in future."

And, how does Dr Chan feel about being an Olympic 'policeman?'

"I guess it's my contribution to the spirit of fair play," he laughs.

Calgary 1988
Olympic Winter Games

Calgary 1988
Jeux Olympiques d'hiver
Feb. 13 - 28, 1988

Chan: Toxicology's contribution to spirit of fair play

THE BACK PAGE

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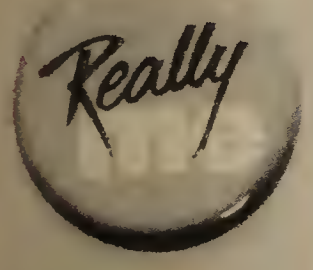
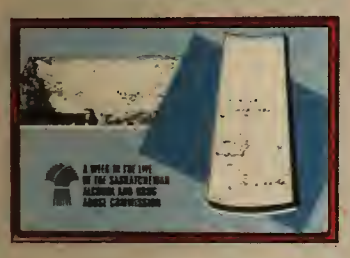




World governments toughen stance

United Nations drug role expands

By Anne MacLennan

VIENNA — A first ever declaration by governments around the globe of high-level, political commitment to vigorous and balanced action against drug abuse and trafficking is a "very major step forward."

But, political will must be translated into results, and "everything now depends on proper and sustained follow-up everywhere — nationally, internationally, and in the United Nations system," says Margaret Joan Anstee, a UN under secretary-general and the new coordinator for all UN drug-related activities (see page 2).

"One hopes it will lead to renewed efforts in all countries, and also to additional resources," Ms Anstee told **The Journal** in a private interview as the two-week International Conference on Drug Abuse and Illicit Trafficking (ICDAIT) [**The Journal**, July] here drew to a close.

The political declaration is one of two documents hammered out, and approved by consensus of 138 participating governments at ICDAIT.

The second is a handbook of program options, for national and international authorities, in the areas of prevention, treatment and rehabilitation, and enforcement.

But the political declaration — the one that should add volume to the voice of international expert opinion — gives short shrift to the question of resources. In three-and-a-half pages of otherwise lofty prose, the phrase "within existing resources" appears in the second-last sentence.

Health Minister Jake Epp, Anstee in Vienna: Marking Canada's accession to the UN 1971 Convention on Psychotropic Substances

Yet even while ICDAIT was on, Ms Anstee, director-general of the UN at Vienna, was walking her own fiscal tight-rope: cutting by 15% regular budget posts in the Vienna office while maintaining all mandated programs.

When the conference ended, it had added to the UN's classic responsibility for supply control and trafficking interdiction that of international coordination of drug abuse prevention, treatment, and rehabilitation.

Ms Anstee: "There is a certain contradiction in all of this. We're being asked to cut down at the same time as we're being asked to do more."

However, it "very much is a duty of this complex of organizations here to work in a concerted way to ensure that political will gets translated into practical activities. We can be a catalyst."

The most important thing, she said, is that "this is a terribly dramatic problem that requires international cooperation. It lends itself to being tackled by the UN system."

Allowing that "our reputation has gone down," she agreed if the job is well done, a spin-off benefit could be a refurbished reputation.

"People don't realize the ordering of our world that is done by the UN. If we can do a good job, by all means let it bring home to people that we do things that touch them in their daily lives."

Ms Anstee told the conference closing session she has no plans for some "expanding new bureaucracy" and is maintaining the ICDAIT secretariat in her own office until year-end, when ICDAIT funding is scheduled to lapse. At that stage, she plans to replace the secretariat with a unit of probably no more than three professionals and consultants. She said her aim is to enhance and support the efforts of existing drug units and programs.

For more on the UN: pp2, 16

TORONTO — In Canada, an executive implementation committee on the national drug strategy (The Journal, July), and five working groups that will report to it, have been set up by the federal/provincial advisory committee on alcohol and other drugs.

Their task over the next six weeks is "to begin transformation of the strategy into program elements, on the demand reduction side, that have some impact," Joan Marshman, PhD, president of Ontario's Addiction Research Foundation and chairman of both the advisory and implementation committees, told The Journal at press time.

The working groups — on awareness and information; community programs; education and training; research and evaluation; and, fiscal arrangements — are to report by the end of August. The advisory committee meets in September in Yellowknife.

AIDS still rocking addictions field

By Harvey McConnell

WASHINGTON — Fear of the spread of AIDS is changing the way the chemical dependency field, the general public, and politicians view intravenous (IV) drug users, their habits, and their sexual partners.

The number of papers and poster reports from the United States and Western Europe at the 3rd International Conference on AIDS here, and a packed roundtable discussion by a number of experts in the field, spelled it out.

The epidemic has finally brought thinking to bear on issues among IV drug abusers "which we have long neglected," said Charles Schuster, director, US National Institute on Drug Abuse. These include myriad medical problems such as the high rate of depression among heroin addicts.

"Yet, rarely do we see an individual in a methadone-maintenance program being treated for both." They may not be causally related, but both need to be treated, along with a variety of disease states. And, questions of education and job skills need to be addressed, "if we are really going to be effective."

Beny Primm, director, Addiction Research and Treatment Corp, Brooklyn, New York, said there is a great deal of animosity toward IV drug abusers and homosexuals in black society. They are *persona non grata*.

There needs to be mobilization of minority organizations in concert with whites who can provide needed expertise.

Dr Primm attacked fellow blacks and timorous whites for under-reporting and underestimating problems in the black community from IV drug abuse and AIDS.

"We must risk being called racist when we make remarks that are the truth, particularly from the public health point of view, and in alerting people of this country to the facts."

Joyce Jackson, New Jersey State Department of Health, pointed to the high AIDS rate among women in the state and to the large number of pediatric AIDS cases. There is no single way to address the needs of women: they will not come into treatment, for example, if the state removes their children.

Ms Jackson suggested methadone-maintenance centres should develop into family care centres where addicts can be helped and families assisted in dealing with the realities of AIDS infection.

Don Des Jarlais, PhD, New York State Division of Substance Abuse Services (**The Journal**, July), said in North America and Western Europe there is now a division into pre-AIDS and post-AIDS periods. "I think politicians, the general public, and especially experts in the drug abuse field, will start to make that division in the way they think about narcotic addiction and injection of illicit drugs".

See page 3

'Significant' increase

Saskatchewan funding boosted

REGINA — While most provincial departments faced cuts under Saskatchewan's new budget, the Saskatchewan Alcohol and Drug Abuse Commission (SADAC) was given a 69% budget boost.

SADAC received $13.2 million for 1987/88, compared to $7.8 million the previous year.

Its 1987/88 budget continues enhancements of approximately $4 million that were first announced in September, 1986 under a provincial initiatives program on alcohol and other drug problems.

These included initial funds for Whitespruce Drug and Alcohol Treatment Centre near Yorkton, Canada's first specialized youth treatment centre.

SADAC Executive Director Howard Greenstein told **The Journal** he is "very pleased we've been able to build on some of the premier's initiatives announced last September."

Aside from renewing the $4-million initiatives funding, the 1987/88 budget marks a 20% increase in operating funds for SADAC, Mr Greenstein said.

"It's still probably the most significant increase of any commission in the country in recent years."

Contributing Editor **Harvey McConnell** takes a look at SADAC this month, pages S1 to S4.

NEWS

Briefly . . .

Anti-doping pact

OTTAWA — Sports officials from Canada, the United States, and Western Europe have agreed to work on an international charter to eliminate performance-enhancing drugs from amateur sports. Otto Jellinek, Canada's Sports Minister, told *Canadian Press* he will urge the Soviet Union to join the charter to establish uniform sanctions and testing procedures and to deal with blood-doping, anabolic steroids, and a variety of other drugs.

End of an era

LONDON — Britain's plan to extend pub hours from 11 am to 11 pm, Monday to Saturday, spells the end of an era, some critics complain. The change does away with the traditional afternoon pub closing, first introduced in World War I to ensure munitions workers stayed sober, says the London *Sunday Times*. The old hours, says a British author, helped sustain pub-going as a ritual. "If a pub only opens at certain times, then everyone goes at that time. It gives a deadline and a shape to the day."

Pizza gang squashed

NEW YORK — Five leaders of the "pizza connection" heroin-smuggling ring were sentenced here to up to 45 years in prison, reports *Reuter*. Four were ordered to pay restitution of more than US $2 million to victims of drug addiction. The drugs were distributed through a network of United States pizza parlors between 1975 and 1984.

Temperatures rising

LANSING, Michigan — Hot bodies get drunk faster, says a University of Southern California researcher. *The Bottom Line on Alcohol in Society* says Ronald Alkana has found a direct relationship in mice between body temperature and brain sensitivity to alcohol: a rise in temperature increases the potency of alcohol, and a drop diminishes its effects.

Forfeiture funding

AUSTIN, Texas — The Texas Legislature has tapped into funds raised through forfeiture of drug offenders' property to help pay for drug abuse prevention and treatment. Municipalities and counties must use no less than 25% of the funds to offset costs of community-based services. Representative Larry Don Shaw told the *Newsletter of the Texas Commission on Alcohol and Drug Abuse*, the bill is "a way to reduce the damage caused by those who sell drugs to our neighbors and our children."

Snuffed out

LONDON — Retailers in East Anglia have been asked to join a campaign to stop the sale of snuff-dipping products in the region. *Alliance News* reports that more than 800 shop-keepers have signed up and some larger retailers have extended the local ban nationwide.

Margaret Anstee

New UN drug coordinator

By Anne MacLennan

VIENNA — Margaret Joan Anstee, the person now responsible to the Secretary-General for coordinating all United Nations drug-related activities, has 30 years of experience in development work, much of it 'hands on,' across the globe.

A British national and the first woman to reach the under secretary-general level, Ms Anstee was appointed director-general of the UN in Vienna in May and head of the Centre for Social Development and Humanitarian Affairs. She became drug-coordinator following the International Conference on Drug Abuse and Illicit Trafficking (ICDAIT) here in June.

Since 1982, she has served as the UN Secretary-General's special representative for Bolivia, a country for which she has special regard and about which she has written.

Prior to her Vienna appointment, Ms Anstee was the Secretary-General's special coordinator to ensure implementation of the General Assembly's decisions on the recommendations of the high-level intergovernmental group of experts (known as the Group of 18) on the financial and administrative functioning of the UN.

The group's report is a critique, with recommendations, of a system which has grown increasingly complex and inefficient (see The Back Page).

Concurrently, from September, 1985 to early 1987, she was the Secretary-General's special representative for coordination of multilateral assistance to Mexico, following the earthquakes, and chairman of the UN working group to study the World Food Council.

In 1967 and 1968, on leave of absence from a series of UN postings in such countries as Colombia, Uruguay, Bolivia, Ethiopia, Morocco, Zambia, Bangladesh, and Chile, Ms Anstee served as senior economic adviser in the office of Harold Wilson, then Labor prime minister of the United Kingdom.

Anstee, earthquakes, food

National 'battle' on smoking launched

By Betsy Chambers

HALIFAX — It's war," said Gerald Bonham, MD, Canadian Public Health Association representative from Calgary, helping unveil the battle plan of Canada's National Program to Reduce Tobacco Use.

"The tobacco companies have already appreciated it is a war," he said, "raiding the files" to find out what the steering committee is working from.

The committee has outlined the first national strategy to try to combat smoking by Canadians in a glossy 28-page booklet.

"We know we can't compete with the $75 million the tobacco companies put into advertising, but we have to at least have our message heard," says Barbara Jones of Edmonton, steering committee chairman.

Aimed at producing Canada's first non-smoking generation by the year 2000, the program proposes legislation, informative smoking prevention programs, citizen action groups, policy development and coordination, and more research.

"I defy anyone to take a look at this document and come out the other end a conservative," challenged Dr Bonham.

The program document lists some worrisome trends and offers some controversial solutions to curb the smoking problem that leads to 30,000 premature deaths in Canada each year and makes Canada one of the world's biggest tobacco product consumers.

The committee would like bans on advertising, promotion, and sponsorship by tobacco companies; on cigarette vending machines where people less than 18 years have access; and, on smoking in public areas, workplaces, and on public transportation.

It would also like to see restrictions on retailers selling tobacco products, incentives to stop selling cigars and cigarettes, a ban on tobacco sales in pharmacies and hospitals, the earmarking of a portion of tobacco tax for counter-advertising and non-smoking programs, and as high a priority for smoking prevention as for fighting other addictive drug use.

Work on the program began in 1985 when eight non-governmental organizations and representatives of provincial, territorial, and federal governments began to meet.

The directional paper "represents the first time in Canada all the issues around smoking have been put into one document by all the major parties," Dr Bonham told the 78th conference of the Canadian Public Health Association here.

Support, he said, has been building for Bill C51, Health Minister Jake Epp's legislation outlawing the advertising and promotion of tobacco products in Canada (**The Journal**, June). When the House of Commons adjourned for the summer recess, the bill had not received third reading.

The national program's committee also includes delegates from the Canadian Cancer Society, Canadian Council on Smoking and Health, Canadian Public Health Association, Canadian Medical Association, Physicians for a Smoke-Free Canada, Canadian Pharmaceutical Association, Canadian Lung Association, and the Canadian Heart Association.

Vancouver health dept successful in ending workplace tobacco use

HALIFAX — With little fuss, people in Vancouver have stopped smoking at office desks — because the city's health department took the time and trouble to find out people prefer it that way.

That's how Geoffrey Rowlands, director of Vancouver health services, analyzes how and why Canada's first municipal bylaw regulating smoking in the workplace was adopted in 1986.

He told the Canadian Public Health Association Conference here marketing techniques used to devise and sell the bylaw succeeded because of attitudes city residents held about smoking in the first place.

The health department received more than 7,000 telephone calls and letters on the bylaw, which regulates smoking in indoor workplaces and public areas; only about 30 were against.

Getting the bylaw passed took 12 months of strategy, using epidemiological data, marketing, planning, and public relations.

Cig sellers draw line

HALIFAX — Most of Woodstock, New Brunswick's cigarette retailers no longer sell tobacco products to juveniles, thanks to a low-budget pilot program sponsored by the provincial Health and Community Services Department.

It's too early to gauge the effectiveness of the Business for Kids campaign, which started in April. But preliminary results are encouraging, says William Howard, a department health consultant who organized the project.

And, other jurisdictions are showing interest, he told the 78th annual conference of the Canadian Public Health Association here. "We've had inquiries . . . from right across the country, even from the United States." Newfoundland and the Northwest Territories are developing pilot projects of their own, and British Columbia is considering one.

Business cares

Business for Kids is based on the premise that too much underage smoking is aided and abetted by ill-informed and thoughtless retailers.

The program alerts retailers to the weak, but still extant, 1908 Tobacco Restraint Act, which forbids the sale of cigarettes, cigarette papers, or cigars to anyone under age 16 years.

While admitting the Act is rarely enforced, the program attempts to induce retailers to obey the law anyway. It points out the harmful and addictive effects of smoking on young people and appeals to community pride and responsibility.

The program reinforces the idea "this business cares for kids."

NEWS

Social marketing can aid in health education

'The odds are you can get some of your message across'

By Betsy Chambers

HALIFAX — Social marketing, a trend in health education, works but has its limitations, warns A. Peter Ruderman, PhD, a professor of community health and health administration, Dalhousie University.

The social marketing concept is best at improving people's awareness, attention, or understanding, he told the 78th conference of the Canadian Public Health Association here.

The success rate is a little lower when it's used to try to persuade people to do something they have never tried before. And, it is even less efficient at prompting lifestyle or behavioral changes, he said.

But, despite its drawbacks and frailties, Dr Ruderman is a booster of social marketing, advocating a persistent, methodical approach to its use, and realistic expectations of results.

If the aim is to spread information, he said, social marketing is very useful.

"While there are always a few people resolutely determined to know nothing, if you select the right message and the right media for your target population, the odds are you can get some of your message across," he said.

On the other hand, propelling people into action — to have a pap smear, get immunized, or have a blood pressure reading — is more difficult, but possible.

Where would-be social marketers can really run up against a brick wall is in the area of behavioral change, trying to get people to stop smoking, or adopt a new life-time diet.

Dr Ruderman: "There are a few people who sway easily at one end, a large number who will respond only partially, after you have put in a lot of effort over what may be years, and a few who just won't be changed at all."

The psychographic nature of the people the marketing campaign aims to reach can give clues as to where the target group fits in the spectrum. Social marketers should react accordingly.

"I'm frankly telling you to take some values as given, rather than beat your head against a stone wall to try to change them," he said.

"How do you get religious fundamentalists to view AIDS as a disease which is to be fought rather than as a punishment for sin?," Dr Ruderman asked.

"AIDS raises the question whether marketing skills are of any use in creating such a major value change when the condition, in my view, seems to pit the two deepest biological imperatives — the preservation of the individual and the propagation of the species —against each other."

Dr Ruderman suggests that "when the laggards or resisters are in the majority and marketing fails, you can resort to legislation.

"When they are in the majority, you may have to give up and wait until they die off or are outnumbered and you can try again.

"My own belief is that you can change some knowledge and some action and some behavior by unremitting effort, even when you have little or no leverage over values.

"Whether you are going to achieve a lot or a little, your work is likely to be more cost-effective if you emphasize research to provide hard data for planning, segmentation, and other marketing skills for appropriate selection of targets," he said. "Do plenty of pre-testing at every stage."

He said social marketing has "been studied reasonably scientifically for the last 50 years, so there is nothing new about it." It follows common-sense rules which those working in health planning, evaluation, administration, and epidemiology may already have the skills to apply.

AIDS and IV drug users: the issues, the reality

WASHINGTON — The 3rd International Conference on AIDS here was a unique scientific event: more than 7,000 delegates and 850 journalists and technicians made it the largest conference ever on a single disease.

For those in the chemical dependency field, where conference attendance in the hundreds is good, it was fascinating to see thousands from outside the field listen raptly to reports about intravenous (IV) drug use and users and shooting galleries and ways to sterilize users' works. Heterosexual transmission of the HIV virus from the IV community is the reality.

"We dare not wait until a vaccine can be deployed against the new adversary, if ever," said Donald Hopkins, MD, deputy-director of the United States Centers for Disease Control.

"Even among the most optimistic projections, the score of this pandemic will be decided before any hoped-for vaccine can come to our rescue."

The cost of controlling the disease was given attention. "Global AIDS control will require billions of dollars over the next five years," said Jonathan Mann, MD, director, World Health Organization's special program on AIDS. "The disease has assumed pandemic proportions affecting every continent of the world, and further spread of the virus is inevitable."

International meetings of ministers in Asia and the Americas will precede a world summit of health ministers in London next January. Organizers of the international conference have already scheduled conference sites through 1992: Stockholm, Montreal, San Francisco, Florence, and Boston.

from Harvey McConnell

Female partners at risk

WASHINGTON — A study of 96 women partners of AIDS-infected men has found that, on average, the women face a one-in-1,000 chance of infection each time they have sexual contact with an infected man.

The study by University of California at Berkley researchers indicates 23% of the women (22) were infected with the virus. Those with the highest rate of infections were women who had had several hundred sexual contacts with an infected partner or partners from any risk group and those who had sexual contact with infected IV drug users.

James Wiley, co-director of the research survey centre, said that while the risk may be one-in-1,000 for each sexual contact, it does not mean women can beat the odds against infection by reducing the total of their sexual contacts or avoiding contact with men from high-risk groups.

Even women who stay with an individual sex partner for a year still face the risk of infection from partners who have been exposed to the HIV virus.

The study showed the highest risk of infection (36%) was among women who had more than 600 sexual contacts with an infected man or men. Forty-two per cent of the women who had had sexual contact with infected IV drug users were infected, as were 22% of the women who had had sexual contact with bisexual men.

The women's chance of infection increased if they already had open lesions from other sexually transmitted diseases, or if partners were later-on in the course of AIDS.

Culture/condoms

WASHINGTON — John Newmeyer, Haight-Ashbury Free Medical Clinics, San Francisco, said here: "There is evidence drug abusers do not take well to condoms." It is called the 'John Wayne Garcia' phenomenon: "Among blacks and hispanics, condoms are just not culturally acceptable."

Multiple partners

WASHINGTON — A study of prostitutes in south Florida shows the highest incidence of HIV infection in those who also use intravenous (IV) drugs, with an added risk from multiple heterosexual partners from an area where there is a high incidence of AIDS.

In contrast, Margaret Fischal and colleagues at the University of Miami found no cases of HIV-positivity in women from an escort service who were economically better off and high school grads.

One anomaly Dr Fischal said they could not explain is that there is no significant correlation between sero-positivity in women who also engage in receptive anal intercourse, the major source of infection among homosexual men.

Cancer experts on watch too

WASHINGTON — Scientists from the United States National Cancer Institute are keeping close watch on intravenous (IV) drug users carrying the HTLV I and HTLV II viruses which are linked to adult T-cell, leukemia and lymphoma (ATL).

Antibodies to HTLV I, the first retrovirus clearly linked with human cancer, are found in scattered regions of Japan and the Caribbean, but with less than a 1% risk of malignancy later in life.

Stanley Weiss and colleagues, in continuing studies that began among IV drug users in New Jersey in 1984, and later New Orleans, show rates of exposure to the HIV or AIDS virus (formerly called HTLV III) drops from a high of 56% in Jersey City to 1.5% in Camden, New Jersey. The rate is only 0.9% in New Orleans.

However, HTLV I/II infection is 33.8% in New Orleans, predominantly among older blacks, and only 10.2% in Jersey City, compared with 23.3% in Newark. There is also evidence the HTLV I/II viruses have entered into a white abuser population over the age of 40 years.

Dr Weiss said here doctors must keep a close watch as ATL is "explosive clinically" and resistant to treatment. In Japan and the Caribbean, ATL rarely appears and then, probably decades after exposure to the virus.

Dr Weiss: "We are very concerned about the possibility that repeated antigenic exposure as occurs with drug abuse could change that observation as compared with Japan and the Caribbean. An even greater concern is the possibility of interaction that the HIV virus and the HTLV I/II viruses could have.

"There is evidence that other viruses can lead to activation of the HIV virus, and we will follow people in this study to see what the clinical outcomes are. We don't have answers, but we are concerned."

Detox coupons

WASHINGTON — Intravenous drug abusers redeem coupons allowing them three weeks of free heroin detoxification and intense counselling on AIDS at a "quite stunning" rate, said Joyce Jackson, New Jersey State Department of Health.

United States federal funding cuts, starting in 1981, prompted New Jersey to charge between $50 and $135 admission to programs, followed by a modest weekly fee. There was a sharp drop in the number of addicts seeking treatment.

The coupon program started last December with ex-addicts distributing them to users who had never been in treatment. Coupons started to be redeemed the next day, and, in three months, 86% of the coupons — printed so they could not be duplicated — were returned.

Of those redeemed, 96% had at least one hour's counselling on AIDS and 23% decided to enter methadone maintenance programs.

Ms Jackson said young IV drug abusers were the most ignorant about AIDS: 30% believe you cannot die from the disease, and many think they can just look and tell if a person is infected. A follow-up is underway to see if addicts who had counselling have changed their behavior.

Housing the homeless

WASHINGTON — A program of placing homeless patients with AIDS or AIDS-related complex in residential therapeutic communities in New Jersey has been so successful it has been expanded to 25 beds in five such communities.

Patients must be able to walk, be independent in daily activities, have clear mental status, and be drug-free or on methadone maintenance.

There are few reports of other residents in the communities being afraid or anxious: for the most part, they are sympathetic and supportive. The only problem is with programs which won't modify their concepts to accommodate needs of AIDS patients.

Joyce Jackson, New Jersey State Department of Health, said the program is enormously cost-effective: about $267,000 (Cdn $353,588) for housing the AIDS patients in the therapeutic communities, compared with $1,576,000 if they had stayed in acute care.

Sterilizing 'works' works

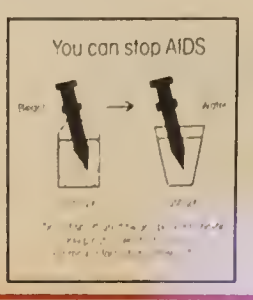
WASHINGTON — One-ounce containers of undiluted bleach with instructions in English and Spanish on how intravenous (IV) drug users can sterilize their 'works' are being used in a United States AIDS prevention campaign.

The campaign has received a significant degree of acceptance, says John Watters, Haight-Ashbury Free Medical Clinics, San Francisco. Some 14,000 vials have been distributed in over a year.

A one-year follow-up shows 91% of the IV drug users interviewed knew the bleach could kill the AIDS virus. Some 68% said they were using bleach for that purpose.

Dr Watters said the data show IV drug users can change their behavior when offered an option which does not require a major change in lifestyle.

Users are told to flush the syringe twice with bleach and twice with water to minimize the chance of any residual bleach being injected. Although the bleach can probably be used a number of times to kill the virus, users are told to squirt it away: this removes the risk of residues clogging the needle.



NEWS

RESEARCH UPDATE

Psychotherapy benefits

Psychotherapy can have sustained benefits in treating opiate addicted patients, conclude four Pennsylvania researchers. Following-up on an earlier study that showed a six-month course of psychotherapy yielded beneficial results, the researchers studied the same patient population a year after initiation of treatment and six months after the conclusion of therapy. The study population consisted of 93 opiate addicts on methadone maintenance randomly assigned to either paraprofessional drug counselling or one of two groups receiving counselling plus professional psychotherapy. A series of self-report psychological tests measuring psychiatric symptoms was administered at the start of treatment and at the seven- and 12-month points. A second set of measures was administered by trained interviewers. The 12-month findings parallelled the positive findings at the seven-month point, with the two psychotherapy groups showing more improvements at a higher level of significance than the drug-counselling group. Continued improvement at one-year was seen in the areas of employment, legal status, and psychiatric conditions with patients who had been receiving psychotherapy. More mixed results occurred with patients in the counselling-only group. The findings also suggest patients in the psychotherapy groups require lower doses of methadone and have less need for psychotropic medications.

American Journal of Psychiatry, May, 1987, v.144:590-596.

MDs' advice on smoking poor

Doctors do a poor job of advising patients to stop smoking, two United States surveys indicate. The random, statewide surveys of 5,875 Michigan residents were conducted in 1980 and 1983. Among other factors, they involved determining whether respondents were smokers, the frequency with which they had seen a physician in the past year, and whether a physician had ever told them to quit. Of those polled, 36% were smokers. The 1,652 who had been smokers for more than one year and had contacted a physician during the last year constituted the study population. In this group, only 44% said they had been told to quit smoking by a physician, despite the finding that more than 73% indicated they had tried to quit or wanted to quit. The four physicians conducting the study said particularly distressing were findings that: less than half the smokers who had undergone a routine checkup reported having been told to quit; young men were least likely (30%) or particularly unlikely to be told to quit; and, only 41% of women who used oral contraceptives and were therefore at risk for cardiovascular disease had been told to quit. The group most likely to receive advice about stopping smoking were patients who had survived either a heart attack or stroke. The clinicians say: "Most smokers do not perceive physicians to be even minimally involved in their efforts to quit."

Journal of the American Medical Association, April 10, 1987, v.257:1916-1919.

Theophylline toxicity warning

Smokers with chronic lung disease being treated with theophylline (eg, Theolair) should have the drug dosage reduced when they switch to nicotine gum (eg, Nicorette), or stop smoking to avoid potential toxicity. That's the advice from a study at the San Francisco General Hospital Medical Center. The study questions the practice of maintaining smokers on pre-hospital dosages when they are hospitalized for acute illness or surgery which requires them to stop smoking. Fourteen healthy, male smokers were used to measure plasma theophylline levels during a 24-day period, while smoking and after a period of abstinence, or after a period of chewing gum with four milligrams of nicotine. The researchers found that after one week of abstinence from smoking, total clearance of the drug decreased by more than a third, and the half-life increased by about the same proportion. Similar drug levels were seen in subjects chewing nicotine gum and those chewing a placebo gum. Given that determining the proper dosage of theophylline is critical because of potential side-effects and the possible development of drug toxicity, the study concludes: even when smokers stop smoking for a brief period, the doses of theophylline should be decreased by one-quarter to one-third.

Annals of Internal Medicine, April, 1987, v.106:553-555.

Opioid addicts and cocaine

Regular cocaine use is rising substantially among patients treated for opioid addiction, say Connecticut researchers. To evaluate the problems, 268 patients applying for treatment for opioid addiction at the Connecticut Mental Health Center and the Yale University department of psychiatry between 1979 and 1980 were questioned about 30 months after treatment began. Overall cocaine abuse had declined minimally in the follow-up period despite treatment. In contrast, the number of patients reporting weekly cocaine use increased to 26% at the time of the follow-up evaluation, from 13% at the time they entered treatment. The researchers found more cocaine use was reported by subjects undergoing methadone or drug-free treatment as opposed to detoxification only. Thomas Kosten, Bruce Rounsaville, and Herbert Kleber speculate that because "cocaine euphoria is not dampened by methadone," cocaine becomes an appealing new drug for those patients who have received methadone therapy and have now become tolerant to the effects of heroin. Depressive disorders were found to be a major prognostic indicator of cocaine use, as was being non-white and male.

Archives of General Psychiatry, March, 1987, v.44:281-284

Pat Rich

National drug strategy follow-up

Canada targets kids in ads

By Terri Etherington

OTTAWA — Dialogue between parents and kids will be the thrust of the second phase of a federal awareness and information campaign on alcohol and other drug abuse.

Following on the heels of the national drug strategy (The Journal, July), the first phase of the campaign includes a series of television ads featuring young people thinking and talking about issues which influence decisions on alcohol and other drugs. It was launched by Health Minister Jake Epp and Minister of State (Youth) Jean Charest in June.

The *Really Me/Les drogues pas besoin* ads promote the benefits of being drug-free to youth aged 11 to 13 years.

Next month (September), a booklet will be mailed to approximately four million parents with family allowance cheques; telephone information lines, accessible to both parents and young people, will also be instituted.

The aim is to promote communication between parents and children and to "better equip parents to discuss the subject with their youngsters."

Other elements of the campaign, developed in collaboration with provincial and territorial addiction agencies, include:

- **resource materials for community groups and youth organizations,**
- **videos for parents and young people, available at video outlets across Canada,**
- **National Drug Awareness Week in November,**
- **special events for addiction workers, including a national networking forum in the fall, and**
- **selected initiatives with private sector organizations — shopping centres, broadcasters, fast-food companies, and convenience stores.**

Ad campaign: promoting benefits of being drug-free

Genetic relapse link possible

By Harvey McConnell

NEWPORT, Rhode Island — A major reason some people return to drinking after a period of recovery may be genetic.

An ongoing study of 140 people surveyed six months after treatment found a significantly higher rate of abstinence among those who did not have a parent or sibling identified as an alcoholic, says Paul Krippenstapel, director, rehabilitation, Edgehill Newport Foundation here.

He emphasizes the data are preliminary and the agency does not want to draw hard conclusions. There could be other reasons to account for the difference, but if there is a genetic history of alcoholism, the chance is 43% higher that patients will not be sober at six months. Among seven people who labelled their parents or a sibling alcoholic, none were sober after six months.

Mr Krippenstapel told the Northeastern Conference on Alcoholism and Drug Dependence here, "We have to be careful not to be seduced by oversimplistic explanations" of relapse. These include: 'He wasn't working his program;' 'He was a dry drunk;' or, 'He hasn't dealt with his COA (children of alcoholics) issues.'

"There is little evidence people have become alcoholic as a result of living with an alcoholic. So, why would we think they have relapsed to alcoholism because they haven't dealt with the issues that don't make them become alcoholic to begin with?"

When a patient says there is something wrong or different about them, "we have to believe them," Mr Krippenstapel added. "Not because we have been trained as counsellors to believe them, but because it's true; there probably is something biologically disharmonious, if you will."

People must not get caught up "in this business about knowledge and statistics and indicators and precipitators and all that kind of stuff. When a client relapses, we are still dealing with a damaged person."

Food addicts often poly-addicted

SAN FRANCISCO — Food dependency is chemical dependency, says Lynn Elliott, program manager of the Henry Ohlhoff food dependency program here.

"It is not just a convenient model, but a parallel disease which seems to have its origins in the same family.

"My hypothesis is that we are dealing with poly-addicted clients who are suffering the effects of the chemicals they have ingested — and I do mean food and not just alcohol and drugs," she added.

Compulsion and bingeing are all part of the pattern, but eating disorders by their nature do not get the spotlight because there is humiliation involved.

"It's becoming almost chic to be alcoholic and drink Perrier. But, there is no possible way to glamorize throwing up in a gas station bathroom," Ms Elliott said.

In their program, abstinence from certain foods believed to be toxic is decided on an individual basis, "and we have to focus on a biochemical restoration program that seeks to supplement what's missing and repair what damage has already been done."

Ms Elliott said she has found the compulsion and hunger for food similar to that for drugs or alcohol: persistence in the face of adverse consequences and in the absence of euphoria. When a client is truly detoxified, the cravings for food leave.

"It doesn't mean somebody who has a fight with a boyfriend and then doesn't want to eat. That's different than feeling like the refrigerator is grabbing them by the throat."

Ms Elliott feels a "family which is dysfunctional has a junk food lifestyle, or you don't have people concerned about nutrition lots of the time.

"I think food may be the primary addiction that underlies the others. We may be talking about food as the mother addiction." Many clients may find "the disease concept hard to accept after years of trying to figure out why they eat."

NEWS

First in-hospital team trained to detect patients' addictions

By Paul Szabo

VICTORIA — The first Canadian project to establish a ward team specifically trained to detect alcohol and/or other drug dependency among hospital inpatients has begun at the Victoria General Hospital here.

The two-year pilot project involves a nurse, social worker, and physician trained to diagnose and obtain proper treatment for patients admitted to the hospital for other reasons, but who are also alcohol and/or other drug dependent. It's estimated that up to 40% of hospital patients have such problems.

Kenneth Thornton, MD, director of laboratory services for the Greater Victoria Hospital Society (which includes the General and the Royal Jubilee, both acute care hospitals), told **The Journal** the project is being funded by the BC health ministry.

Dr Thornton said there has been an "in-situ, highly skilled team" at the General with a specific interest in alcoholism and other drug addiction among hospital patients for a number of years. Gradually, they developed an excellent system of identifying patients referred to them for abuse problems, detoxifying them, and ensuring they receive referral for proper treatment.

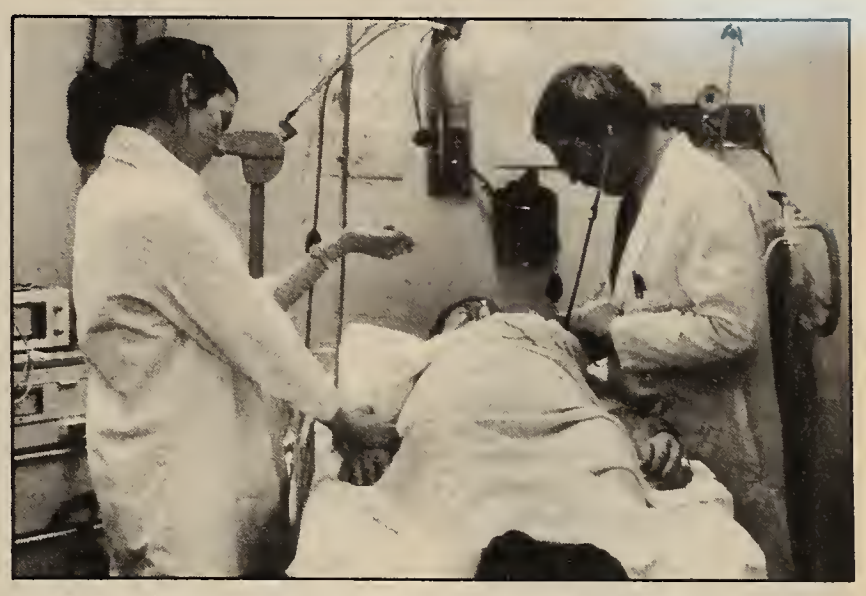
With this team already in place, the hospital was a natural focus when the BC ministry became interested in the concept of a specific team to diagnose addiction problems among hospital inpatients.

Dr Thornton said he has been aware of the high degree of dependency problems among hospital inpatients for some time. In a series of autopsies on 100 hospital patients "some years ago," he discovered "to my amazement" that 40% had alcoholism or other drug dependency as a primary or major secondary etiology.

He has since repeated the study with similar results. And, another physician at the hospital conducted an informal survey among adult male patients and found more than 20% showed clear signs of alcohol and/or other drug dependency.

The health ministry is providing approximately $360,000 for the pilot project. The ward team will identify dependent patients through a number of well-defined triggers: cause of admission, laboratory test results, withdrawal symptoms, and statements by relatives about the patients' conditions or behavior.

Patients' physicians will alert the team to confirm the trigger and make the formal diagnosis of alcohol and/or other drug dependency, thus maintaining traditional medical referral methods.



Hospitals: high degree of dependency problems in patients

Care will be concordant with treatment already underway for the conditions for which the patients were admitted. The ward team will have to decide "how best to involve patients in the recognition of their problems," Dr Thornton said.

"It's inappropriate to be counselling patients about the need for abstinence if they're hanging on by a thread to their physical lives."

Patients' families will also be involved in the recognition of dependency problems. The team social worker will communicate with the appropriate outside treatment agencies, from an inpatient treatment program to self-help groups.

Kaiser Foundation focuses on educational front

By Paul Szabo

VANCOUVER — The Kaiser Substance Abuse Foundation will take a new direction with a major conference on education and alcohol and other drug abuse slated here for early December.

The foundation was created in December, 1985, to address issues of alcohol and drug dependency in British Columbia. During its first year, Kaiser produced the province's first directory of alcohol and other drug abuse services and awarded $51,000 in community grants.

Now, the foundation has decided to focus its attention on the development and initiation of a drug education program for school children from kindergarten to Grade 7.

Ross Ramsey, Kaiser president, says sponsorship of the invitational conference for educators will "inspire, focus, and mobilize a critical mass of essential public and private organizations.

These groups support the development and implementation of a human-growth achieving, curriculum-based, drug education program for youth in Grades kindergarten-to-7 and a companion parent education program throughout British Columbia."

Ramsey: confronting challenges

Kaiser hopes the new education programs will be in place by September, 1989, Mr Ramsey added. They will be integrated with the provincial education ministry's recently announced comprehensive health education program, which includes a number of other health topics, including alcohol and other drug abuse.

Mr Ramsey, a former executive director of the Alcoholism Foundation of Manitoba, told **The Journal** he is enthusiastic about the aims of the Kaiser foundation, which was created by a $2.5 million endowment from Edgar F. Kaiser (**The Journal**, April, 1986).

When he first transferred to British Columbia early in 1986, Mr Ramsey said, he travelled extensively throughout the province and met face-to-face with professionals working in the field to see how Kaiser could best help. From this research, the Kaiser board decided to focus its resources on youth.

In a report, Mr Ramsey wrote, "We intend to confront this challenge by supporting and encouraging adolescents to both reach their full potential and inculcate resistance skills to improve their ability to better handle drug using situations."

At a more concrete level, he found a notable lack of awareness about the resources already available to diagnose and treat alcohol and other drug abuse in BC. This led to the compilation of the first of what will be an annual directory, published in conjunction with the health ministry.

The directory outlines all of the available treatment programs, mutual support organizations, prevention programs, employee assistance programs, and current research in the province. Mr Ramsey said 18,000 copies have been distributed to date.

Also in 1986, Kaiser awarded 20 grants, most in the range of $2,500 to $3,000, to a variety of community groups involved with countering alcohol and other drug abuse. Such groups usually have small budgets, and it was believed that giving grants of this amount would allow them to double their program budgets and have maximum impact.

While the 1986 grants went to a variety of projects, Mr Ramsey said from now on Kaiser will concentrate on awarding money to projects that further the school curriculum project.

The foundation has only three staff members, including Mr Ramsey, but he has found a private group can work with surprising speed.

The foundation has also been welcomed by the provincial health ministry's alcohol and drug programs branch. Executive director David Gilbert told **The Journal** the emergence of the Kaiser foundation here adds "another strength" to addiction programs.

"Historically, we've always had money coming from private foundations into the whole area of helping chemically dependent people," he said. Kaiser "adds to that long history of public/private participation."

Lower alcohol content for low-alcohol products

TORONTO — Low-alcohol beverages in Ontario will contain less alcohol after September 30.

Ontario Consumer Minister Monte Kwinter told the provincial legislature the maximum allowable alcohol content of drinks such as Sarasoda (**The Journal**, October 1986) will be reduced to 0.5% from 1%.

Low-alcohol beverages, which can be sold in food stores to people of all ages, were the subject of a survey by Ontario's Addiction Research Foundation of police chiefs, school teachers, and medical health officers. All three groups reported little awareness of use by children.

Mr Kwinter told the legislature that when dealing with children, "we must be more than just cautious."

HOWELL

Flip Wilson, we need you

"Milton!," exhorted William Wordsworth in 1802, *"thou shouldst be living at this hour / England hath need of thee: she is a fen of stagnant waters . . . Oh! Raise up, return to us again / And give us manners, virtue, freedom, power / Thy soul was like a Star, and dwelt apart / Thou hadst a voice whose sound was like the sea / Pure as the naked heavens, majestic, free . . ."*

Wordsworth was of the opinion that a great poet and moralist would be a good man to have around at times of social crisis. But, David Lewis, MD, professor of medicine and community health, Brown University, Providence, Rhode Island, says the John Miltons of this world are just what we don't need at this point in time.

Speaking at the recent Northeastern Conference on Alcoholism and Drug Dependence in Newport, Rhode Island (**The Journal**, June), Dr Lewis expressed concern that many people were viewing AIDS as the product of "self-injurious behavior" and that these same people might start to consider alcohol and drug use "self-injurious behavior" as well, causing a return to moralistic views of drinking and drug abuse. This, he said, could "change markedly some of the great advances we have made in treating people for the disease of alcoholism."

If you believe that Dr Lewis's concern is a valid one, you certainly would not want to call up the ghost of John Milton to get perceptions of AIDS and/or alcohol and other drug abuse back on track. The author of *Paradise Lost*, the author of such lines as, *"But God left free the Will: for what obeys Reason is free,"* does not sound like the laid-back sort of guy that is in tune with modern perspectives on social problems.

Better to invoke the spirit of someone who is:

Flip Wilson! Thou shouldst be on TV
At this hour: America hath need of thee;
She is a fen of stagnant waters
Where moralists pronounce and whine
On responsibility and self-control:
In these dark days, we need your cry
Expressing the line that is right for the times:
"The Devil made me do it!"

Flip Wilson! thou shouldst be on prime time
At this hour: America hath need of thee;
She needs your voice explaining
How the medieval notion of Volition
And the scholastic concept of Will
Are but irrelevant abstractions,
Long gone and over the hill:
It's the Devil makes us do it!

Flip Wilson! Thou shouldst be with us
At this hour: America hath need of thee;
She is a lake of acid rain
Seething with the cant of moralists
And judgemental vapors most vile;
America needs your falsetto cry
Declaiming the line that is right for the times:
"The Devil made me do it!"

Flip Wilson! thou shouldst be living
At this hour: America hath need of thee;
In these times of Bakker and North
And AIDS and crack and sundry,
We need you more than ever to give
Your twentieth century homily:
Whatever the sport, even the self-injurious sort,
The Devil made us do it!

By Wayne Howell

LETTERS

Researchers must take stance on tobacco ads

Stan Sadava's comments (June) would make for amusing reading were it not for the seriousness of the tobacco epidemic in Canada.

His letter accuses the Non-Smokers Rights' Association (NSRA) of *"ad hominem"* arguments regarding Richard Gilbert. Yet, in the same breath, it is apparently permissible to express reasoned "arguments" by associating NSRA with terms such as "dogmatism, zealotry, and arrogance," "moral entrepreneurs," and "people who are not only fanatical . . . but who are also essentially sophisticated hustlers."

One might wonder why these comments would not be more suitably directed at the tobacco industry which depends on the slick commercialization of addiction and disease?

Many non-profit organizations are trying to reduce the horrendous impact of tobacco products. Rather than continuing their existence, these agencies would gladly see this scourge ended. However, whenever one attempts to improve environmental health, one faces opposition from the tobacco industry.

Unfortunately, issues such as protection of the non-smoker and tobacco advertising are inseparable. One cannot address an aspect of the tobacco problem without also attacking the source.

Since advertising is the means by which the tobacco industry sustains itself — how else could such a lethal product continue to exist in light of such harsh and voluminous evidence? — it is not difficult to see why these organizations would target advertising.

Recently, the federal government has introduced Bill C51, the Tobacco Products Control Act (**The Journal**, June) to bring regulation to a presently unregulated industry which continues to promote its addictive and lethal product to minors.

What is the position of academics and researchers? Is it one of taking responsible action by urging the government that one does not allow an addictive and lethal product to be marketed to children? Or, is it to do nothing, tolerate another 32,000 deaths, and watch another 375,000 kids enter the tobacco market this year?

As a researcher in addiction, Dr Sadava must be aware that for many users tobacco addiction is as difficult a dependency to overcome as heroin.

Yes, it would seem NSRA has a vested interest: the regulation of the tobacco industry — and the sooner the better. Surely Dr Sadava is not suggesting that the profiting of the tobacco industry at the expense of thousands of deaths is a legitimate interest, and NSRA's is not?

The time is long past for "calm and rational debate." We have been doing this for almost 25 years, since the first (US) Surgeon-General's report.

The problem is clear, and the solution is clear. Only those who pontificate from ivory towers, those who have a vested interest in playing the research-grant game, or spokesmen for the tobacco industry suggest we continue to talk instead of advocating action.

Robert Guthrie
London, Ontario

Telling it like it is . . . teachers' story helpful

We are a school support committee in a rural community. Our focal issue is drugs — exclusively. Street drugs and/or careless mixing of prescription drugs leading to a number of near-fatalities in four years caused us to become involved.

We have been active for three and a half years. From the beginning, we have had access to CODA (Council on Drug Abuse) newsletters as well as copies of **The Journal** from Ontario's Addiction Research Foundation.

We consider both responsible for much high-calibre and on-target literature. Many times, we have wanted to reprint high priority items from **The Journal**.

Not many people in rural areas read **The Journal** yet, but virtually every household in three neighboring counties has access to a free newspaper made available via tourism operators, merchants, businesses, etc.

It is there we wish to place articles, such as Terri Etherington's Teachers need help with drug lessons (May). By reading this article, apprehensive and sincere teachers can see that others in their profession share their dilemma relating to alcohol and other drugs in the schools.

And, communities at large can visualize that drugs are in other school areas, and not all in city schools.

Die-hard denialists exist in every rural/city setting. Therefore, we feel very strongly that periodically quoted material from **The Journal** would be a valuable asset in reaching and improving overall education and prevention attempts and, perhaps almost as importantly, in diminishing public apathy.

Helen Mills
Chairperson
Rural Drug Concerns
Northbrook, Ontario

(Editor's note: **The Journal** *is pleased to respond to requests to reprint specific articles.)*

. . . realistic

The article, Teachers need help with drug lessons, was excellent and gave a very realistic description of the needs of teachers and their frustrations in presenting drug education effectively in the classroom.

I was disappointed, however, that you did not follow-up on the subtitle, Give us information to work with, they say, and provide resources teachers could use.

For example, Alcohol and Drug Concerns, Inc (ADC) has two curriculae available to teachers, PLUS I for Grades 4 to 6 and PLUS II for Grades 7 and 8. PLUS I is a new program, but PLUS II is already in 4,000 classrooms across Canada.

It is sad to hear teachers talking about a lack of resources when they already exist. How about doing a follow-up story on the PLUS programs?

Judy Bowman
ADC
Community relations director
Scarborough, Ontario

The Journal

A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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Maplines

REGINA — The Saskatchewan Alcohol and Drug Abuse Commission (SADAC) is one of the more fortunate provincial agencies in Canada. The tremendous budget boost it received last fall has been renewed (see page 1).

SADAC's increased vigor and visibility also come from highly publicized, provincial "initiatives" on alcohol and other drug abuse announced last September: a major public awareness campaign, development of resource materials for schools, a coordinated justice program, and a community prevention program.

The initiatives include establishment of Canada's first free-standing, specialized, youth drug treatment centre at the former Canadian Forces radar base at Whitespruce, near Yorkton.

*SADAC — and the provincial initiatives — are ready to go hand in glove with the national drug strategy (***The Journal***, July).*

SADAC Executive Director Howard Greenstein thinks the national strategy "is the greatest thing to happen in Canada in the addictions field.

"I think we may be looking for the first time at many, many years of real partnership between different levels of government in Canada."

Saskatchewan has a population of just over a million, about 13% to 15% Native.

Contributing Editor **Harvey McConnell** *reports on what's going on at SADAC and how it views the future in the fifth in* **The Journal** *series on Canadian provincial addictions agencies (Manitoba, March; Ontario, October, 1986; Alberta, August, 1985; and Nova Scotia, November, 1984).*

THE DIARY

TUESDAY
9 am
Regina
Youth Services

At breakfast in the slick cafeteria of the new T.C. Douglas health services building, atrium and all, Rod McHugh discusses culture-based treatment services. Mr McHugh recently joined SADAC as coordinator of youth services, and when he arrived from New Brunswick, he was struck by the slight, but evident, cultural differences between the two provinces.

He believes services have to "reflect the culture in which things happen," one of the reasons he looks askance at attempts at the 'McDonaldization' of addictions by some United States groups which think they can simply open shop in Canada without regard to such distinctions.

"Services have to be tailored to the needs of the culture," Mr McHugh insists.

He also says deciding what the biggest problems among Saskatchewan youth are depends on your point of view. "Parents are faced with all of the media information about some of the non-alcohol drugs, and there are obviously valid concerns about marijuana, hash, and other chemical drugs."

But, studies all across Canada show most students use alcohol as the mood-altering drug of choice, followed by tobacco and marijuana at about 25%.

One problem SADAC faces is that "what we really have to do is help parents and other adults be aware of their own attitudes about their own use of drugs.

"I think SADAC approaches it wisely in terms of, 'Let's face the fact we do have problems and not put them under the carpet,' so to speak."

Parents and adults must take a look at their own attitudes, not "leave it to the so-called experts. I think adolescent treatment without parent involvement is a complete failure," says Mr McHugh.

One factor which attracted him to the west is an openness here in facing problems and taking steps to find solutions. "And, it is better to catch them at 15 or 16 years old than at 25 or 26 years, simply on the dollar side.

"Just to say it is not as bad here as it is in the US is a small consolation. We have our own problems which we are objectively facing."

10 am
SADAC Headquarters

Howard Greenstein, SADAC executive director for more than three years, was also struck by the difference in culture when he arrived in Regina. A native of Toronto and trained as a clinical psychologist, he spent 10 years in British Columbia and gradually moved into program development and management, setting up outpatient clinics and helping reorganize the commission there.

"The prairies are a real experience: I didn't realize there was that much variation in culture across the country, but there really is," he observes.

"Some of the things I have learned about here are probably why we've been able to start a lot of programs that haven't happened elsewhere in Canada — in the youth section, for example.

"There is a pioneering kind of spirit: it takes a certain kind of mentality to survive the hard winters here, the population is dispersed, and people have developed traditions I think are much stronger, in some ways, than those I noticed in BC or Ontario."

Saskatchewan people are much more into community organizations, services, and clubs, "and it doesn't seem to be a narrow spectrum of the population who become involved.

"It's the whole notion that your neighbor's barn needs fixing and the community gets together and fixes the barn."

This community involvement has moved forward and into attitudes toward the problems facing the 80s. When issues are raised about alcohol, other drugs, and youth, it is not just the professionals who are interested. It is a topic of conversation throughout the province, and people have a greater sense of ownership.

Mr Greenstein cites the establishment last year of the commission to advise the provincial ministry of health on alcohol, other drug problems, and youth. "I was surprised by the involvement the average person wanted to have. We had briefs and letters from all over the province, from individuals, service groups, clubs, school boards, and teachers.

"We ended up with a travelling road show with meetings in different regions of the province, and almost anyone who wanted to speak did so.

"People take a real ownership of problems. With our long, cold winters, there is not a lot to do, and people traditionally go over to a neighbor's house and sit around over a coffee and talk. And, everybody has an opinion on everything; people want their voices to be heard."

Mr Greenstein, like other Saskatchewan officials, does hear from the people: "Virtually anyone in the smallest rural setting feels that he can pick up the phone and call a cabinet minister and say, 'I feel this about that.' There is a greater freedom of access to senior decision makers."

In his first year as SADAC executive director, he learned not to be surprised when an individual, not a representative of a particular interest group, would drive into Regina to talk.

Thus, when the youth report was released and the extra budget benefits flowed, there was great debate as to what would be done.

Mr Greenstein says the provincial initiatives, with the increase in budget, are key events in the addictions field in Canada — not just for the province. He is not sure these could be replicated elsewhere though, just because the attitudes of people in the province are different.

Mr Greenstein notes Saskatchewan does not have a large industrial base; most income derives from oil, gas, potash, and agriculture. But, as the originators of medicare in Canada, people in Saskatchewan "still expect they are going to have the absolute best quality of everything." And, this means what is available should be available in every part of the province, "and it

(continued on page S2)

A week in the life of SADAC

(from page S1)

should be better here."

He also says that, in recent years, some people in Saskatchewan heard the siren songs of the private, profit-making treatment centres that are so strong south of the border — until they found out how much it would cost for such private care.

Most people in the province realize there is no magic answer to addictions problems and that there must be a long-term effort involving the family.

In Saskatchewan, "family values are quite cherished."

Although cocaine and crack have grabbed headlines here in recent months, fed by the US media, there has been little incidence of their use in the province.

Alcohol is the major problem, Mr Greenstein adds. "But, it is surprising the large number of people whose primary addiction problem is with cannabis." Drinking among the Native population is high, as it is elsewhere in Canada. Saskatchewan has had an impaired drivers' program for a number of years and a special treatment centre for repeat offenders.

The question of drugs and youth has drawn the most intense public awareness obviously and with it has come the realization that more has to be done than just tell young people to say no to drugs.

Mr Greenstein says the province has had some programs for young people and families, but pressure grew for a free-standing centre for youth. The provincial initiatives, and the decision to open a separate treatment centre for youth to be called Whitespruce, not only raised awareness of SADAC within the province, but also increased general awareness of youth drug problems.

SADAC does not support mass urine testing for drug programs: alcohol is the main drug of abuse, and the employee assistance program (EAP) is still the primary vehicle to identify these problems.

There has been a good public response to the agency's commercials, which rely heavily on those produced by the Alberta Alcohol and Drug Abuse Commission (AADAC). But, in the field, it is still unclear what message works for whom much of the time. This confusion, however, should not keep addictions agencies from trying to communicate.

Mr Greenstein: "I am very concerned that a mass media program in and of itself doesn't do a lot. It catches some attention, but you have to follow-up with something tangible."

This means more print matter and broader education programs because the key way to reach young people, he is convinced, is through the school system. Durable programs in schools will have an impact for the next two decades.

And, while Whitespruce is certainly something he welcomes, Mr Greenstein wants to make sure the public focus is on the positive nature of the spectrum of services SADAC offers to all age groups in the province.

Community involvement and enthusiasm here is matched, he says, by the attitudes of SADAC staff. He is constantly awed by the degree of productivity in such a small organization, and how the staff has been able to develop and put into place so much new programming in recent years.

"The only thing that concerns me is that people are so committed, they may burn themselves out.

"What we want to emphasize is the comprehensive nature of what we are trying to do and to get everybody involved — rather than saying, 'Here are all these shiny new dollars, here are all these shiny new programs.' I don't think that really is the point. Interest and involvement will be there, whether there is money or not."

1 pm
Indian Head
Regional Services Southern Division

Lyell Armitage, who was born in the province, spent a decade in Vancouver, BC, before returning to become SADAC's director, southern division, regional services. He is a fount of local information on the drive from Regina to Indian Head and the Pine Lodge treatment centre.

Pine Lodge is one of the more recent additions to SADAC's funded agency panel.

He and Ray Gerry, director, Regina detox centre, point out that the building, which has been completely refurbished, was at one time the headquarters for a tree farm.

Mr Gerry extols the "very cooperative relationship" he has with SADAC. "They have to be commended: they involve themselves all through the development stages and ask all of their questions before there is any type of commitment. But, once they make up their minds, they leave it to the society, or the group, or whatever the case may be, to run the day-to-day operation."

He says Pine Lodge is a catchment centre for Saskatchewan, but there is an exchange agreement with Manitoba and Alberta for clients.

Mr Gerry has no doubt that the emphasis must be on working with the disease of alcoholism: the day begins for the 28 clients at 7:30 am and doesn't end until 11 pm. The only real problem at Pine Lodge is the waiting period for entry: it's already six-weeks long, although staff strive to keep it to three weeks at the most.

3 pm
Regina
Provincial Services

More funding for SADAC means more to oversee for Danni Boyd, SADAC associate executive-director. She is responsible for the provincial services division which includes prevention and training, evaluation and research, and administration.

"At the present time, we are looking at contracts to establish some kind of service agreement with our agencies as opposed to a financial agreement," Ms Boyd explains.

She oversees 34 programs run throughout the province by 27 non-profit corporations. The programs range from outpatient, through treatment and detoxification centres, to halfway houses; the organizations include Native addictions councils, and the Metis and Non-Status Indians Association.

Under the provincial initiatives, Ms Boyd is also working out funding for the expanded youth program. Outpatient centres in the north have increased to eight from four and operating criteria have been worked out with the communities.

She says one of SADAC's most interesting pilot projects is in the small rural town of Kipling where the agency has funded an outpatient centre. "Now we're putting funds into a small, rural hospital for a couple of detox beds, plus extensive training with doctors in the community and the nursing and aid staff in the hospital. This is so they won't fear the whole detox process and will accept clients there."

She adds SADAC depends, to a large extent, on the funded agencies. "and we need to keep the partnership strong."

Coming on-stream, of course, is Whitespruce. "and there are still a lot of decisions to be made."

WEDNESDAY

9 am
Evaluation and Research

As director of evaluation and research for SADAC, Bob Markosky has access to provincial data that his counterparts in the rest of Canada and the US would love to have. Computerized records in the provincial health care system allow a wide range of studies.

"Alcohol continues to be the number one problem in terms of consequences, and tobacco continues to be the worst, in fact, in terms of health care costs and in terms of years of lost life," he explains.

Research has covered a number of areas since the late 1970s, and one of the most controversial has been a study of prescription drug abuse.

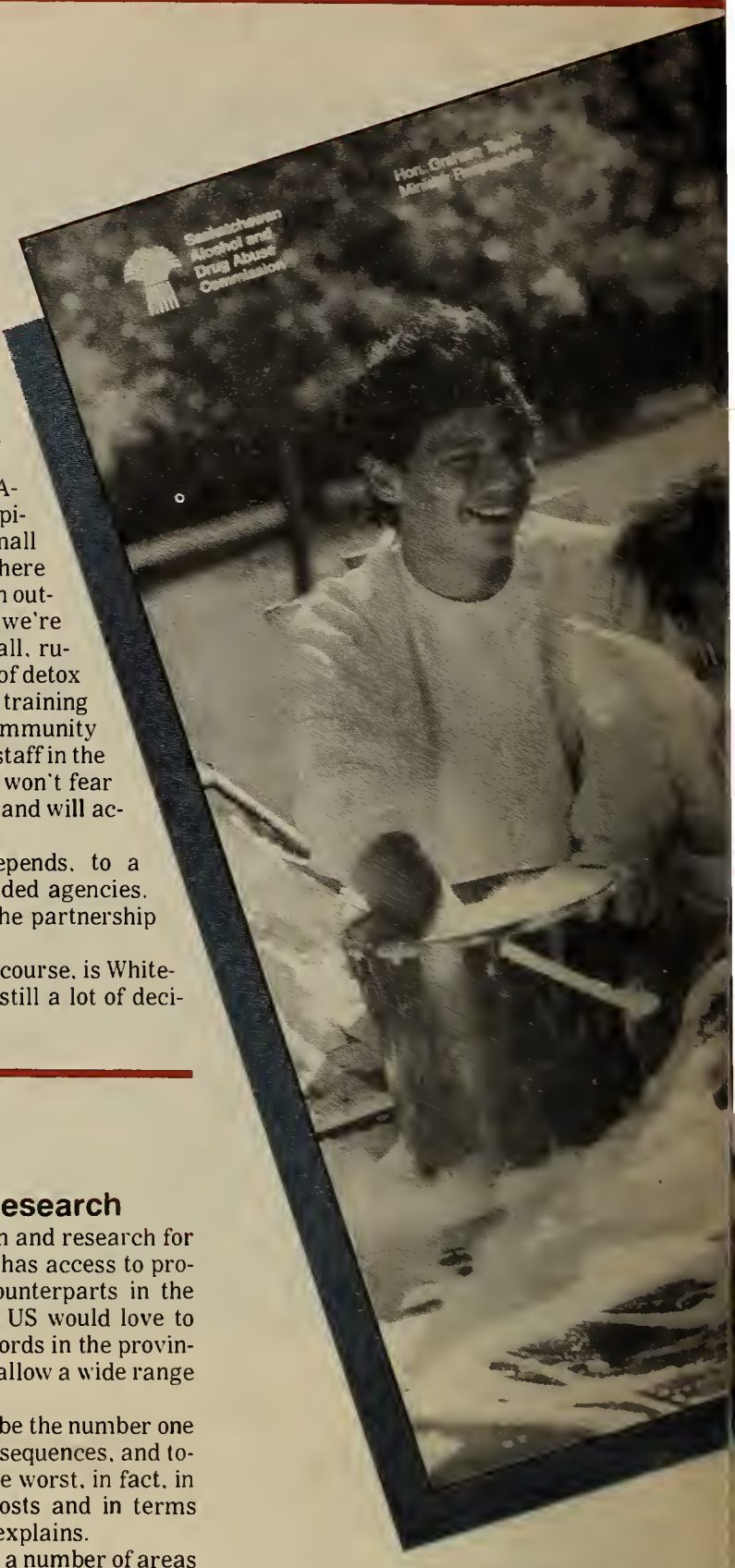
"We have switched gears in the last couple of years — a lot more time is concerned with using existing health data bases to do research. We have the reputation of having the best data base in North America because it is linked: everywhere you go for health services in the province, the files can be linked.

"We can track people with health care disabilities right through the health care system and we can position them geographically."

Mr Markosky has a number of beautiful overlays which he exhibits at conferences. They are of "what we call community profile projects. It is an attempt to merge all the various sources of data and use that as a tool of analysis to look at what is going on in various communities."

The picture includes data on health, hospital separation, medical care, insurance, doctors' services, and mental health service as well as data from SADAC's own information system.

"We have profiled that in 124 geographic areas in the province, or basically, the Royal Canadian Mounted Police catchment areas. With this, we can figure out



treatment rates for particular kinds of communities, and offence rates, and allow some comparison between communities and the provincial rates to get an idea of the extent of the problem."

The data give the commission valid indicators and useful guides and responses. "This allows us to make reasoned judgments about the best places to select new services or where to position new services, and allows us to address issues in a broad way — the social or economic cost of substance abuse.

"We can talk about health care utilization and health care cost and the impact of that on the health care system."

One of Mr Markosky's current studies is on suicides, using records in coroners' offices. He points out, "Saskatchewan is the only province that has a compulsory toxicology report on any suicides, homicides, or suspicious, accidental deaths."

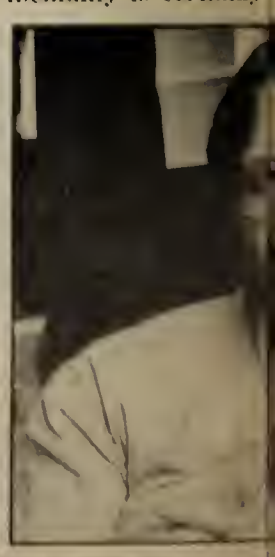
10 am
Prevention and Training

Allan Walker, as SADAC director of the prevention and training division within provincial services, and Saskatchewan-born, knows his market. "Many people think the survival mentality is certainly

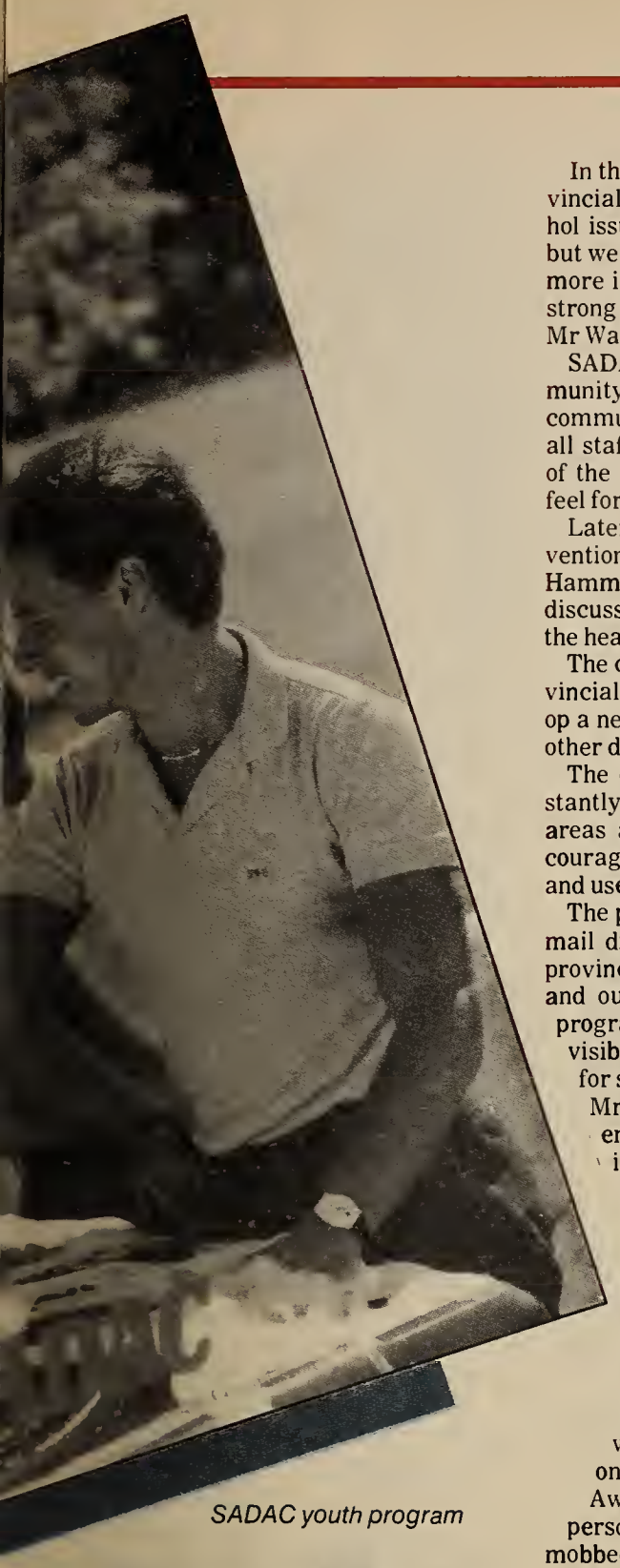
Tait: working with COAs

Armitage: fount of information

Boyd: keep partnership strong



Walker: people's survi



SADAC youth program

part of our psychological makeup. A quarter of our population is involved in farming, and over half live in small towns around farms.

"Everyone has relatives who are on farms or in small communities, and this rural background is part of our makeup. There is little emigration; the population is like it was 50 years ago — many families go back four and five generations."

Unlike neighboring Alberta with its boom-and-bust economic situation, Saskatchewan has not gone through such turmoil, and times are not so bad even with recent provincial budget cuts.

The provincial initiatives announced last September and the resulting increase in SADAC's budget demonstrate growing public concern about addictions issues. Mr Walker notes that problems of alcohol and other drug abuse have not increased dramatically: "It's just that people are more concerned as they see the havoc wreaked." One of the main concerns is specialized treatment for young people.

SADAC has found in recent months that, with its intensive training and public awareness programs, a lot of people from other areas — social workers, teachers, mental health workers — have shown interest in alcohol and other drugs.

"For many of their clients, alcohol and other drugs may be the primary or secondary problem. We have been quite pleasantly surprised by other professionals and their interest."

In the past, the commission's image provincially has centred chiefly around alcohol issues. "We want to retain that focus, but we also want to be seen to do, and to do, more in the prevention area. Our board is strong on the healthy lifestyles approach," Mr Walker says.

SADAC programs have to reflect community structure: there are more than 300 communities that the agency serves, and all staff members are expected to get out of the T.C. Douglas building to acquire a feel for things.

Later, with other members of the prevention and training division staff — Carol Hamm, Randi Kelly, and Karen King — discussion turns to school programs and the heavy use of audio-visual materials.

The commission is working with the provincial Department of Education to develop a new health curriculum on alcohol and other drugs.

The demand is there — SADAC is constantly hearing from young people in rural areas asking for materials; teachers encourage them to write papers on the topic and use SADAC as a reference.

The provincial initiatives allow for more mail distribution of materials around the province on a number of issues, from detox and outpatient centres, through training programs and general services. Higher visibility means an increased demand for services.

Mr Walker: "There has been more emphasis on the audio-visual, including television spots, modelled mainly on the AADAC program." The Alberta commission was happy to let SADAC use its materials, and the only change has been the logo and voice-over at the end of the spots.

One of SADAC's big supporters is Roger Aldag, for many years a lineman for the Saskatchewan Roughriders. He was featured on posters during the 1986 Drug Awareness Week (see page S4) and, at personal appearances, is always mobbed by young people.

Mr Walker: "Normally, we don't use celebrities in our campaigns. But, Roger is an exception because of his long track record in community services and as a role model for youth."

If the medium is the message, then SADAC is onto a winner; the media in the province are exhibiting great interest in SADAC material and use it. "We get air time with our public service announcements which we never ever would be able to afford."

Under government regulations, 15% of the time given to alcohol advertising has to be on education, and broadcasters view SADAC material as part of that 15%.

The commission initiated the media support through a half-day meeting in Saskatoon with the owners and managers of all the major media outlets in the province. Staff outlined what the situation really is here with alcohol and other drugs, and there was a consensus more needs to be done.

1 pm
Training

Public training by SADAC has increased enormously in recent years, considerably expanding its base, says Ernie Epp, head of training.

"We are getting more professionals from the fields of education, health, psychology, and medicine. Three assessment sessions last fall drew 160 people, and the number with professional training in other fields was noticeable."

Mr Epp: "Industry and the workplace is also a growing area of need, and we are essentially oversubscribed for every course. Also, we are getting more requests from school counsellors interested in a one-day training module."

One of the major demands from educators is in the legal area: rights, responsibilities, and protocols in terms of alcohol and other drugs. What should be done if drugs are found in a student's locker, or students are found to be using drugs at a school dance? A fine-tuned package is being developed for school boards.

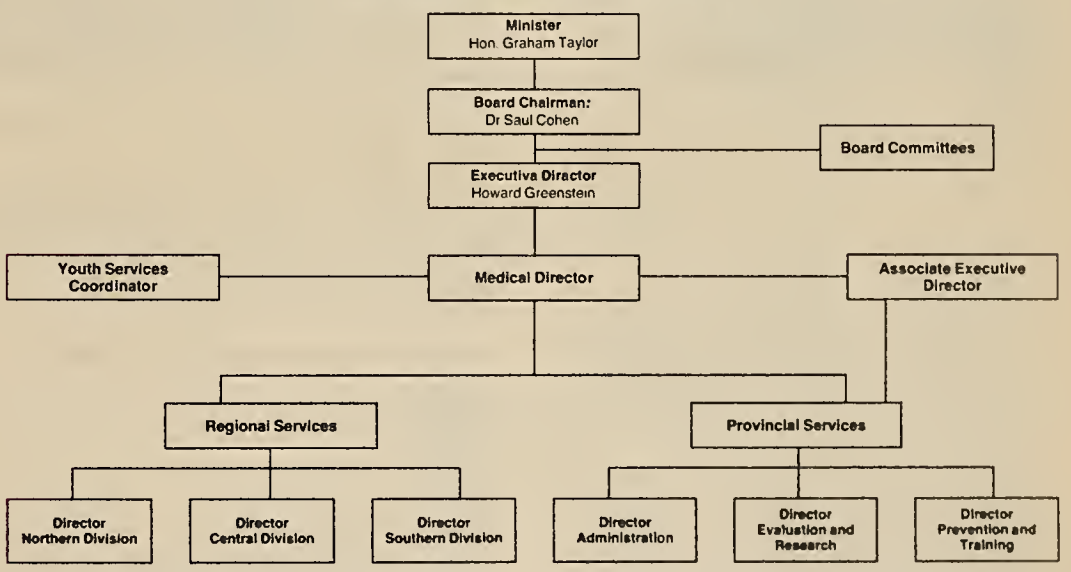
Training programs in youth assessment and family therapy are also being expanded. "We try to be relevant and tailor quite a bit of our training accordingly," Mr Epp adds.

Bob Giles, EAP coordinator, has run the commission's EAP program since 1975 and is SADAC's consultant to 78 provincial organizations, actively developing EAP programs for a range of settings: hospitals, teachers' organizations, the potash industry.

If a particular organization wishes, SADAC can put together a package without direct consultation with their employees. In most cases, however, the provincial agency acts as consultant at an advisory level, ensuring that the organization is updated on a regular basis and acting as a consultant in specific situations.

Mr Giles is the author of SADAC's training program procedural manual — "we have sold 200 of them and are just publishing another 200 copies." He also started the Saskatchewan EAP administrator and counsellor organization, which holds a one-day conference each year.

SADAC organization structure



Mr Giles: "We are very proud of our EAP program. It is well accepted, and cost-effectiveness is apparent."

3 pm
Regina Rehab Centre

Couple counselling in treatment is nothing new at the Regina rehabilitation facility — it has been going on since 1970. "When I was in British Columbia, we used to refer people back here," Lyell Armitage says.

"They not only take couples but also spouses of alcoholics who are reluctant to participate. The spouses come in for three weeks so they can come to understand the dynamics of the illness. It introduces them to self-help programs for the families of alcoholics."

Supervisor Tom Dolan says the couples program has paid off well. "The bottom line is that we are treating alcoholism and chemical dependency: rather than treating the drug, we treat the couple."

The rehab centre has 34 beds. Adolescents are admitted if they are considered mature enough to participate in the program. The centre also runs a methadone maintenance program for about a dozen addicts in the city.

THURSDAY
6 am
La Ronge
Regional Services
Northern Division

It's a clear day for flying: the early spring melts the prairie. Further north, winter still holds, grey and cold. On a four-wheel-drive ride from the air strip to his office, John Kreiser, director, northern division of SADAC's regional services, and Bruce Chamberlain, coordinator, La Ronge, outline some history of Lac La Ronge, for thousands of years a gathering place for the Cree Nation each summer. Today, there are two reserves in the area, both with alcohol and other drug abuse programs.

Mr Kreiser explains that about one-third of the people living in the north are treaty Indians; the rest are Metis and white.

Since the 1970s, with a marked growth in tourism, La Ronge has expanded. Attempts to create industry have had mixed success. One success is a wild-rice growing and processing plant.

This success can be countered by the all-too-familiar poor treatment of Natives in North America that still goes on: a fish-processing plant jointly owned by Natives and a local "entrepreneur" did well until the entrepreneur skipped town.

Fortunately for those who still trap, La Ronge has in Alex Robertson an honest fur trader and buyer. Mr Kreiser: "He is the biggest fur buyer in the north, and his prices are better. He extends credit and fronts trappers with winter supplies; people trust him and depend on him."

But, the land can't support trapping by everyone, so tourism, wild-rice growing, and government jobs — teaching, social work, and nursing — are the only real employment opportunities. The out-of-work level is high.

Drinking here is in the old, true-frontier style: to get drunk. At Christmas, many people go on a two-week drunk, although

(continued on page S4)

ntality

Epp: fine-tuning school package'

Kreiser: fur trappers and traders

Fafard: breathing space needed

A week in the life of SADAC

(from page S3)

those who trap stop the minute they leave for the traplines. "The big problem is for people to learn how to drink normally."

Mr Kreiser has written extensive reports on the situation with the Native population in the north and suggested changes to improve the situation.

Mr Chamberlain points out there are times police and social workers won't go into communities "because it is too damn dangerous — everybody is drinking, and the whole community is drunk."

Roads have reached some communities only in the past five years; this creates more problems as alcohol becomes more easily obtainable.

There is a large Chippewa population as well as the Cree in the north. The Chippewa are wanderers and used to isolation: even to settle in a small village is too much for some. They can't cope with neighbors, their dogs, and snowmobiles.

This problem is coupled with the fact employment opportunities are higher for women than for men (social workers, nurses, etc).

"Traditionally, the males are gatherers, not care-givers; with not enough to do, many drink, and the violence follows," Mr Chamberlain says.

Mr Kreiser believes that "while it is a very general rule, it seems to me that the further north you get, the worse the drinking is. There is less exposure to the outside, less education, less literacy. And, with no coping mechanism, even the chiefs and band council members are drunk."

Alcohol and other drug problems among so many people were not new to Mr Kreiser when he joined SADAC more than four years ago: he had already done family-service work up north. Today, he has six coordinators; every second week, he is out in the bush by plane. And, it can still be tough.

"When you see the kids, sometimes you could cry: runny noses, teeth rotting, and parents out drinking. It was discouraging at first, but now I think we are making headway and getting support in many communities from the Native people.

"The number of people interested in staying sober may not be to the degree we would want, but many leaders in communities are sober now. It is starting to turn around a bit. By and large, though, many communities are still in bad shape."

The message SADAC officials try to give to people in the north is that by staying sober, while they still might not have a job, they can have gardens, take care of their houses, look after their children, and help the community with volunteer work. The people are told: "It's a cop-out to say, 'There is no job for me when I sober up, so I will stay drunk.' "

It is a slow process, Mr Kreiser adds, "in changing from out-of-control drinking to moderate, controlled drinking. There are always going to be some problems."

At lunch, Claude Fafard, a provincial court judge living in La Ronge, outlines some of the problems he constantly sees from alcohol and other drug use. "I would estimate alcohol is a factor in the infraction 95% of the time.

"I know it is a controversial statement. But, I sometimes feel that the problem is so great we need more breathing space to address it from a fresh start, to give people the chance to be employable. No alcohol.

"I realize this would bring all kinds of problems with enforcement, but I wonder if it would better for us to have the law enforcing prohibition as opposed to investigating crime and violence as we have it now."

Judge Fafard says many young men who come before him have records that go on for pages. If an individual has been sober for a couple of years but relapsed, he takes this into account.

One feature of the north all across Saskatchewan is solvent- and gasoline-sniffing among Native youth. "Up here, it tends to be seasonal; we don't know why," Mr Chamberlain says. Young people sniff gasoline primarily in the summer and the Christmas holiday.

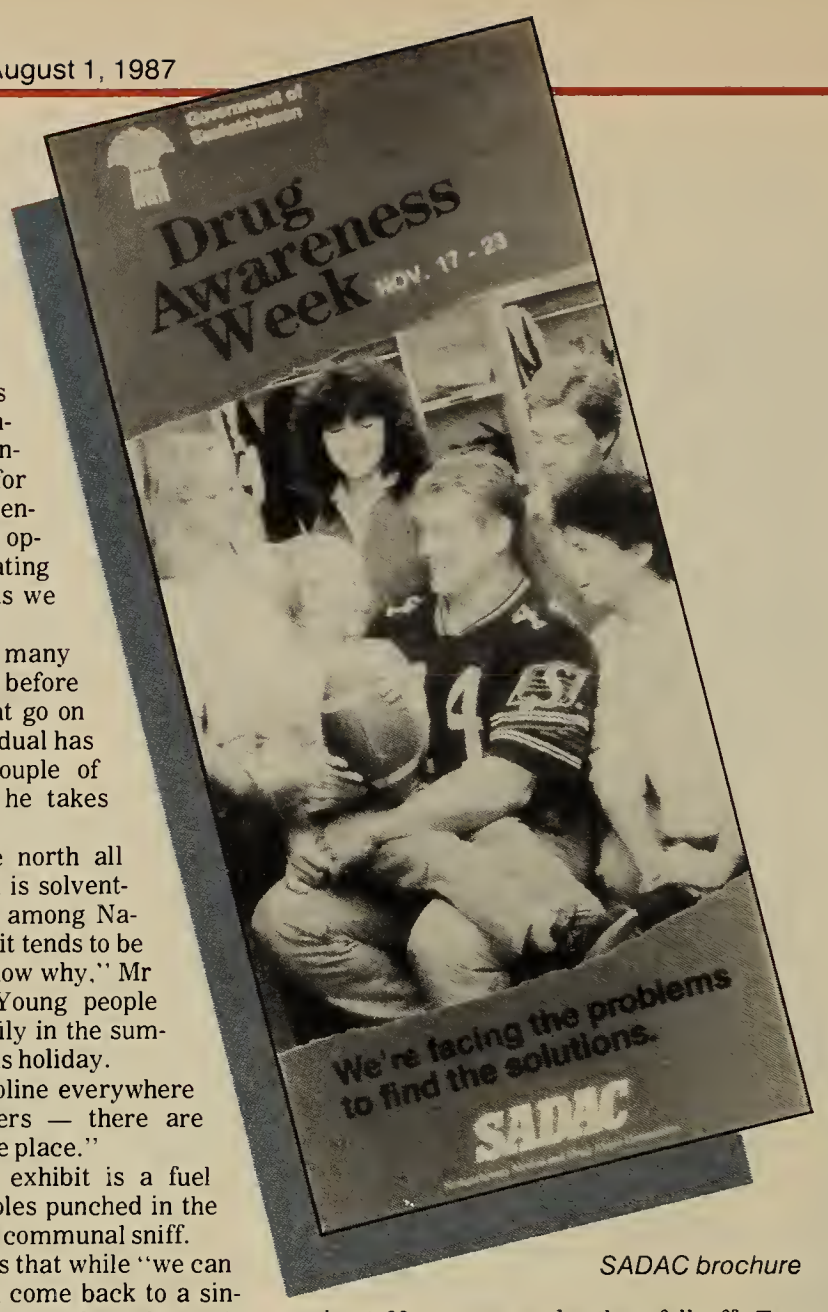
"And, there is gasoline everywhere — fishermen, trappers — there are cans of gas all over the place."

One prize SADAC exhibit is a fuel drum with several holes punched in the top that kids used in a communal sniff.

Mr Kreiser declares that while "we can treat kids, they often come back to a single-parent family and a mother who can't cope with a big 16 year old. There is a need for more foster homes. Those who sniff tend to come from homes where there is little structure left: the dad has long gone, either drunk or dead."

The future lies in some cases with the VCR (video cassette recorder): good programs for use on local television stations. "Television can be a tremendous ally."

Overall, Mr Kreiser believes that in the north, "we have come full circle now; from the down-side, we are a now clawing our way back." But, there is still a long way to go: every month when government cheques arrive, Mr Kreiser stays in La Ronge for a couple of days.



SADAC brochure

FRIDAY

Saskatoon
9 am
Central Division

At breakfast, Lynn Tait, director, central division, regional services, gives a rundown of SADAC activity in the division and her work with a number of funded agencies.

Ray Burke, community program consultant, outlines his work with an impaired drivers' treatment program in the Saskatoon region. He tries to assess if someone convicted of driving while impaired (DWI) has a drinking problem and, if there is one, puts on pressure for them to attend AA (Alcoholics Anonymous) meetings. If the offence seems to be due more to the occasion or situation, "then we provide more information about responsible drinking and try to work with the family."

Jean Dunlop, alcoholism counsellor, says they are trying to revive Solvents Anonymous in the region. It began with about 20 young people, then fell off. Ten years ago, they started groups specifically for addicted women and "as outreach expands to the elderly, there has been an increase in the case load."

She points out that in this area of the province, "there are a lot of wealthy farmers. It has been stated that there are more pickup trucks and more new vehicles per capita than anywhere else in North America."

Rick Kuckartz, Saskatoon youth and family service coordinator, is a new member of Ms Tait's staff. He is working with about 95 young men, average age 16 years, who have been using drugs on a regular basis since they were approximately 12 or 13 years old. "Cannabis is the main drug of use, a lot more than alcohol." In some cases he finds "the family is more of a problem than the drug."

En route to the Calder Rehabilitation Centre, a treatment facility at Saskatoon's St Paul's Hospital which has been in operation since 1971, Ms Tait explains some history and adds, "One of our long-range plans is to have a free-standing facility."

Al Hergott has been Calder supervisor since mid-1985. The 40-bed facility has six beds devoted to youth aged 12 to 18 years and nine beds for the 19-to-25 age group. "The young people get the same basic lectures although our counsellors do other, more specialized lectures that are pertinent to adolescents.

"We have few one-drug addicts: alcohol is often the last drug of choice in some cases, although it is more common for alcohol to be first."

Ms Tait points out that since the 1960s, they have worked with spouses and children of addicted parents and a special youth program is run during school vacation in the summer. This program is not designed for addicted young people, although some who attend are addicted.

Mr Hergott says the centre worked with 16 different professional groups in the past year including a kind of practicum for doctors and a one-day-a-week "kind of storefront legal kind of thing" for lawyers.

A new research program is an anxiety study being conducted here with the department of psychiatry at the University of Saskatoon. We're using screening instruments to see which of our clients have a sufficient level of phobia to be a part of the study."

Eventually, the hope is to devise a system in which clients can deal with phobias without the use of any drugs.

Later in the day, a visit to Crysler Residence, a funded agency which has been directed for a number of years by Dennis McElligott. "We can accommodate 15 people here. The minimum length of stay is one month, and the average is about two months. It usually works out that when the house is no longer doing anything for the individual and the individual for the house, we part company."

The object is for the residents to find work, and "if they have an allergy to work, then they have to go somewhere else."

Mr McElligott runs a co-ed facility — women make up about 25% of the population — and he is very conscious of the threat posed by AIDS and the possibility of HIV-positive clients. He wants to know if a client is HIV-positive "because sometimes sex goes on amongst clients — I hate to say it, but it's true."

Ron Fleming, newly appointed director of the Larson Intervention House detox centre, Saskatoon, was previously in the correction services. "And, the system seems to be full of drug addicts and alcoholics, so we are trying to refer people to Calder Centre and Lawson House."

The 28-bed facility is nearly always full: in 1986, the average daily census was 23.5, Mr Fleming points out. "We could probably keep 40 beds full."

Many clients are referred from the northern part of the province. "At the moment, we have people from Prince Albert, North Battleford, and Meadows Lake and just yesterday, I had a call from Onion Lake."

About 65% of the clients stay two weeks, and 10% to 15% from one week up to three weeks.

Our final visit is to the Native Alcohol Council Centre which opened in 1973; the director is Bertha Ouellette.

Ms Ouellette arrived in 1974 and has seen many changes: "When I first came, the majority of the clientele were male; then, after two years, I could see more women coming in, and that progressed more as time went on. And, the age got younger in the last five or six years. Now, the trend seems back more to the male again."

The clientele is young: from 16 years to the early 20s; alcohol and other drugs are the major problem — the younger people are more involved with marijuana than the older ones.

Those who relapse have to wait: "I have them wait at least six months, and what I recommend to them is that they try meetings or outpatient services rather than inpatient. Some may not end back up in here, but others will.

"I will make them wait out: I can't just keep taking the same people over and over again," Ms Ouellette says.

There is a waiting list of new people. The program is for 30 days, and the average stay is 21 to 22 days. "I think that's pretty good."

SADAC offices: La Ronge

Northern view: Lac La Ronge

Pine Lodge treatment centre: Indian Head

INTERNATIONAL

Hong Kong's smoking prevention policy works

Habits change significantly within the first two years

By Lachlan MacQuarrie

HONG KONG — A comprehensive government policy of legislation, education, and publicity, together with large tax increases on tobacco products, has led to a drop in the number of smokers here.

This was suggested in a study by Judith MacKay and Geoffrey Barnes, Effects of strong government measures against tobacco in Hong Kong, in the *British Medical Journal* (May, 1986) and confirmed by a recent government study.

Dr MacKay, Hong Kong United Christian Hospital, and Mr Barnes, former deputy-secretary, Health and Welfare, say the pattern of smoking here is quite different from that of Europe or North America. The percentage of smokers in the population is smaller, approximately 19% of people over 15 years. Only 4% of women smoke, but 45% of men over 60 years do.

In the 1960s and 1970s, the authors note, a combination of mild government restrictions, low-key publicity, and a voluntary advertising code had little effect; the annual per capita consumption of tobacco remained constant at approximately two kilograms.

By 1980, however, there was clear evidence here about the hazards of smoking. Lung cancer deaths went up by 92% to 1,826 in 1981 from 949 in 1972, and deaths from lung cancer as a proportion of all death increased by 62%. The fire department determined 33% of fire accidents were caused by careless smoking.

A 1981 public opinion survey showed clear public support for strong anti-smoking measures, and the Smoking (Public Health) Ordinance was passed (**The Journal,** April, 1983), introducing compulsory health warnings on cigarette packages, limited smoking on public transportation, and smoke-free areas in theatres, cinemas, restaurants, schools, hospitals, and public areas of government offices. Public health education was increased, and a major anti-smoking publicity campaign launched. Large tax increases on tobacco products followed.

Within two years, significant changes in smoking took place. By 1984, the number of daily smokers fell dramatically to 745,000 from about 890,000 in 1982. There was a 37% decrease in cigarette imports and a 23% decrease in locally manufactured cigarettes. A 1986 survey confirmed the trends were continuing; the number of daily smokers declined further to 700,000.

One worrying fact is that the number of daily smokers under 19 years — which had fallen to 11,000 in 1984 from 22,000 in 1982 — rose to 17,000 in 1986.

The Hong Kong government is not relaxing its anti-smoking stance. A Council on Smoking and Health has been set up with an annual budget of HK$1 million (Cdn $170,000) to intensify preventive education and to advise the government on further measures.

In January, the Public Health Ordinance was amended to prohibit the importation, manufacture, and sale of smokeless tobacco products.

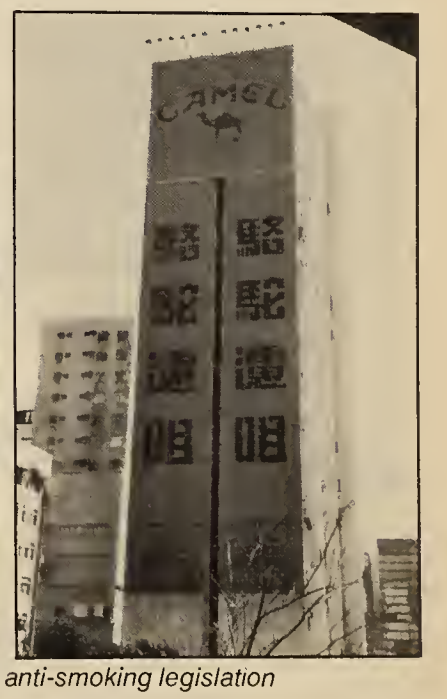
Recently, measures were announced to phase out tobacco advertising on television. Because Hong Kong does not produce tobacco, government revenue from this source is not significant and the tobacco lobby is weaker than it might otherwise be.

The tobacco industry is a major force in advertising though; seven of the top 20 spenders are tobacco companies — in 1986, they spent HK$230 million, much of it on television.

However, Hong Kong Attorney-General Michael Thomas has introduced plans to change this. By 1990, there will be a total ban on tobacco ads and sponsorship on television and radio.

Reaction from the Tobacco Institute of Hong Kong has been mainly to attack the government as having "scant regard for public opinion" and being contrary to "Hong Kong's tradition of free enterprise and freedom of speech."

These are sensitive issues here as Hong Kong evolves from the status of British Colony to Special Administrative Region of China in 1997.



Signs of the times: Street ads may disappear under upcoming Hong Kong anti-smoking legislation

A prevention checklist

HONG KONG — A symposium on tobacco-related problems here was given a checklist of six measures to reduce tobacco consumption:

- stop promoting tobacco,
- use public education and public information programs,
- add health warnings on product packets,
- raise the price through taxes,
- reduce the emission levels of toxic components, and
- control public smoking.

The symposium preceded the first-ever international meeting on smoking and health to be held in China. The world's largest producer and consumer of tobacco, China is becoming increasingly aware of tobacco hazards (The Journal, March).

GILBERT

Arguing for tobacco

This is not a column arguing for tobacco. It is a column about a book entitled *Smoking and Society: Toward a More Balanced Assessment* (D.C. Heath and Co, Lexington and Toronto, 1986), edited by Robert B. Tollison, George Mason University, Fairfax, Virginia.

In an introductory essay, the editor sets the tone for 12 substantive chapters: "There is another side to the smoking issue, and it is time it had a fair hearing and a fair chance to influence public policy."

In a concluding essay, Mr Tollison outlines "some of the more prominent lessons to be drawn from the preceding chapters:"

- The scientific case with respect to the causes and effects of smoking is not established.
- There is no substantive evidence to support the view that environmental tobacco smoke presents a significant health hazard to non-smokers.
- Smoking produces ill-understood benefits in social settings.
- The case for restraints on public smoking, properly practised with courtesy, is weak.
- Anti-smoking groups are motivated by self-interest.
- The marketplace can provide for peaceful coexistence of smokers and non-smokers.
- Restrictions on the production of tobacco worsen the economy.
- Tobacco taxes are regressive and unfair and worsen the economy.
- There is no good evidence that advertising alters the number of cigarettes sold.
- If all activities regarded as bothersome were regulated, everyone would be worse off.

Mr Tollison's concluding point is that the anti-smoking crusade is the first of a series of assaults on individual liberty that, if unchecked, will produce a "totally regulated society."

I dealt with the advertising issue earlier this year (June, February, January).

Much of the argument in the book for the other six of the last seven points seems to me to be little more than libertarian polemic, sophistry, or claptrap. For example, James M. Buchanan, George Mason University, in making the case against the regulation of "bothersome" activities, lumps together leaf burning, possessing handguns, and using seatbelts as the subjects of "politically orchestrated regulations" designed to impose the will of the majority on the liberties of minorities.

Societies seem happier, healthier, more productive when expression is unrestricted

The value of the book is that it raises questions that are difficult to answer. Why, for example, do I dismiss a defence of the right to bear handguns, but support freedom of expression to the extent of defending advertising by cigarette manufacturers, however misleading? I respond, lamely, with the assertion that societies and their individuals seem happier, healthier, and more productive when expression is unrestricted but that the opposite seems to apply for handguns.

The first three points in Mr Tollison's list are of different stuff. The four chapters on which they are based comprise well over half of the volume. Salient is the longest chapter of all, by Hans J. Eysenck, entitled *Smoking and Health.*

Dr Eysenck — as iconoclastic in his 70s as when I attended his lectures at the University of London 28 years ago — examines in detail the evidence that smoking causes lung cancer and coronary artery disease.

Here is his conclusion: ". . . The received view — that smoking causes lung cancer and coronary heart disease and is responsible for the major portion of the deaths that occur from these two causes — has not been proven correct by existing research, but has encountered so many anomalies and difficulties, and is based on such insecure foundations (largely due to the lack of reliability of the data and the incautious use of statistics based on these data) that the only possible conclusion is a verdict of 'not proven.'

"On the other hand, the constitutional view, particularly when integrated with work on personality and stress, can successfully account for some facts, although it is also weak with respect to causal mechanisms. The position thus clearly remains one of doubt and questioning; either theory might be right, both theories might be right and complement each other, or possibly both theories in the present form might be wrong. This may be a pessimistic conclusion to draw from such a large amount of research, but it is the only conclusion that is scientifically admissible at the present time."

Dr Eysenck's analysis is sound but limited. The epidemiological arguments can never be conclusive. They define association and only hint at cause.

Cause is buttressed by knowledge of the nature of tobacco smoke, which Dr Eysenck ignores. There are known carcinogens and cocarcinogens in the smoke, notably benzo(a)pyrene and catechol. There are compounds that have a toxic effect on the cardiovascular system, notably nicotine and carbon monoxide. The broad consensus among scientists that smoking causes lung cancer and cardiovascular disease is based on assessments of all of the evidence.

Dr Eysenck argues well that smoking is neither a necessary nor a sufficient cause of lung cancer or coronary heart disease. There are undoubtedly other potential causes, including genetic factors. Chromosomes probably doom some of us to be predisposed to smoke, and some to be susceptible to cancer or heart disease. The final statement on the hazards of smoking will undoubtedly accommodate these vulnerabilities, and environmental impacts too. Meanwhile, we should welcome Dr Eysenck's vigorous criticisms of part of the story.

The balance of evidence has only recently tipped on the side of harm from environmental tobacco smoke (ETS) to healthy adults who are chronically exposed. The weight of evidence is slight enough that one or two well-conducted, contrary studies could move the scale the other way. The chapter by Domingo Aviado, Atmospheric Health Sciences, Inc, does not provide such evidence, but the contrary conclusion of his review serves to remind us of the fragility of the currently accepted view of the hazards of ETS.

Science is enhanced by debate about the value and meaning of data. It generally leads to improved understanding and accuracy. Analysis of the hazards of smoking is being retarded by the politicization of this area of scientific endeavor. Questioners risk public and professional vilification. Books such as *Smoking and Society* are rare and valuable.

The rarity of publication of the arguments found in *Smoking and Society* raises questions about the origin of the volume. Mr Tollison's preface notes that it was an outgrowth of a workshop on smoking and society held in New York city in 1984 that brought together "a group of concerned scholars to address the conventional wisdom about smoking." In a call to the editor, I learned that participants in the workshop were paid by the tobacco industry, but that the book was not otherwise subsidized.

The tobacco industry's involvement should have been acknowledged. Withholding the information raises more doubt about the quality of the book's contents than giving it.

By Richard Gilbert

INSIDE OUT

Retreating to silence

I'm sitting on a white wooden chair up on a hill and looking down and out at the loveliness of the earth spread in a soft, endless sheet of perfect browns and yellows and greens, on top of which rests an infinite blanket of perfect blue. The sun is giving its final performance of the day, teasing my eyes and cheering on my full heart as it slowly removes all its props from the stage below and, oh, I am so at ease.

The only sounds are coming from the birds, and their songs appear to be lofted high in applause at how serene and beautiful everything is right here now.

I am at a monastery out in the countryside, away from the city where I live and work. And, I am thinking, I have come full circle again in yet another of God's mesmerizing surprises.

Almost five years ago, almost in another life, I went to another monastery like this, to stay quiet somehow and to hide away for a few days from the madness engulfing me. I had gone on a retreat, and I was certainly in retreat.

I had not arrived — stumbled is more like it — at that place of silence because I'd been tugged by the urgings of faith, because I had no faith. No, nor had I gone seeking simple solutions to my deepening quandary because, even in my condition — and it consisted of a cowardice propped up by a mountain of lies — I knew the only solution was for me to change my life from the bottom to the top.

I guess I had gone on that long-ago retreat because there seemed nowhere else left: I was wretched, lost, and ashamed.

I felt this way largely because the evidence pointing to my addictive disease was becoming overwhelming. But, I continued to pretend that it wasn't absolutely right there, in my eyes, in my shaking hands, in my sad, hungry heart.

No, my agenda on that journey to a medieval past with hooded monks was hidden from curious acquaintances. When they asked why I was going away to the country, I gave answers that I hoped were mysterious. They were instead, I know now, flip or curt or cute. I liked then, after all, to be thought of as different, more than slightly exotic. Do you know what I mean?

So, what could be more far-out for a holiday than a monastery where silence ruled?

What I really wanted to find out — and what I never told anyone — was whether I could stop drinking for three or four days, something I hadn't done for more than a decade without having to face delirium tremens, or a terrifying insomnia, or all of the other demons I feared were straining to get out from beneath my none-too-shiny surface of smugness.

And, I found out . . . .

I discovered I could survive a few days without a drink. I didn't get the heebie-jeebies, although I had trouble getting to sleep at all that first night. I had some fearful moments, it's a fact; but they were related, I told myself, to the awful silence of the place and to my feeling like an impious impostor who had infiltrated a battalion of blessed believers and who kept expecting the God I didn't necessarily believe in to strike me down on the spot, for impudence.

I left there, that first retreat, confirmed in my smugness, ready to keep on lying to myself about where I was heading. When I got back to the city, I went on a monumentally mindless bender that scared me worse than any I'd been on before.

But, I didn't pay attention for long . . . .

Instead, I plunged into my own final performance before all of my props were removed, one by one.

Those last two years, after 'winning' my wager at the monastery, constituted a dizzying reckless race to the end of the line. The only props I had left to hold on to were the gray blanket on top of the white sheet on the blue bed in the hospital.

Now, as I sit on top of the hill, the sun's gone down; it goes out as I remember all that, years later, at this, my second retreat.

This time around, I am seeing it all whole, all plain, all clear. I have no hidden agenda for being here.

This time around, I can see the possibility of thinking again of renewing a long-ago faith. I feel as if I belong here, somehow.

So, I leave the hilltop and the white wooden chair, and I head back inside the main building. I walk down the quiet corridor and I stop in at the small library and look at the books and the tape cassettes on the shelves.

There on a bottom shelf at the back of the room are some pamphlets grouped together around a single theme. One of the titles reaches out to my eyes.

It says: *A Brief Guide to Alcoholics Anonymous.*

This column, exploring addictions from the "inside out," is by a freelance Canadian journalist.

Career opportunities

REVIEWS

New Books

by Margy Chan*

Drugs and the Brain: An Introduction to Neuropharmacology

. . . by John Brick

Written for laymen, this booklet introduces the major categories of psychoactive drugs and their effects on the central nervous system and behavior.

It is one of the first titles in the Centre of Alcohol Studies pamphlet series, designed to provide clear, concise, and relevant information on selected topics of current interest. Other titles in the series now available include: *What Shall We Teach the Young About Drinking?*, and *Employee Assistance: Policies and Programs*. The educational pamphlets are ideal for workshops, seminars, high school and college programs, parents' groups, and business and industry programs.

Rutgers Centre of Alcohol Studies, Piscataway, NJ 08855. $2.50.

How to Use Intervention in Your Professional Practice: A Guide for Helping Professionals Who Work With Chemical Dependents and Their Families

A detailed model for intervention training and programming developed by the Johnson Institute is provided. The book is a guide for helping professionals, providing the principles, guidelines, techniques, and strategies they need to guide families and others through interventions with alcohol/drug dependent people.

A special section on issues and concerns raised by professionals in intervention provides insight into some commonly asked questions. Further resources for programming — an annotated list of selected Johnston Institute materials — will be useful for those who want to develop formal intervention programs for their treatment centres, agencies, organizations, or private practices.

Johnson Institute, Minneapolis, Minnesota 55403-1607, 1987. 100 p. $8.95. ISBN 0-935908-41-2.

Alcohol and Other Drugs: Self-responsibility

. . . by Ruth Engs

This book gives readers information to develop self-responsibility in decision-making in the use and/or non-use of a variety of medications, recreational substances, and other drugs found in the North American culture.

Reasons behind drug use are discussed, as are the process of decision-making, physiological effects of various substances, process of stress response, and nature of various other addictive behaviors in addition to alcoholism and drug abuse. Stress reduction techniques and various alternative activities to alcohol and other drug use are suggested. Information on first aid for acute drug overdose, intervention, and referral to treatment is provided.

The illustrations, statistical tables, charts, and exercises will stimulate discussion and provoke serious thinking for readers.

Tichenor Publishing, Bloomington, Indiana 47402, 1987. 387 p. $22.95. ISBN 0-89917-473-6.

Books received

Battered But Not Beaten . . . Preventing Wife Battering in Canada — Linda McLeod. Ottawa, Ontario. Canadian Advisory Council on the Status of Women. 1987. 181 p. ISBN 0-662-15428-2.

Coming Off Drugs — James Ditzler and Joyce Ditzler with Celia Haddon. London. Macmillan, 1986. £5.95; Cdn $12.75. ISBN 0-333-41855-7.

Dual Disorders: Counselling Clients with Chemical Dependency and Mental Illness — Dennis C. Daley, Howard Moss, and Frances Campbell, Minnesota, Hazelden, 1987. ISBN 0-89486-449-1.

ISSN0044-6203 Printed in Canada

ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

National Teen Alcohol Test

Number: 792.
Subject heading: Alcohol and youth.
Time: 28 min.
Synopsis: At a lecture for high school students, Craig Braun asks students to think about 13 questions to help them understand if they have a problem with alcohol or other drugs. As each question is asked, recovering teenagers tell of their experiences with alcohol. They also relate how they feel now that they're recovering. The narrator cautions that if anyone answers yes to three or more of the questions, he or she has a problem and should get help.
General evaluation: Good to very good (4.8). Although the film is a series of talking heads, it is well done and captures attention. The film could lead to good discussion about the problems associated with alcohol and other drug use and encourage those with problems to seek help. General broadcast is recommended.

Recommended use: With a resource person, the film could benefit those 15 years and older.

Smokable Cocaine: The Haight-Ashbury Crack Film

Number: 796.
Subject heading: Cocaine/crack.
Time: 28 min.
Synopsis: Crack has received a great deal of media attention. People who smoke it feel the effects quickly as crack reaches the brain faster. The dose reaching the brain and the resulting side-effects are also greater. Treatment for crack use is difficult: relapse is common, and total abstinence seems the only solution.

General evaluation: Very good to excellent (5.6). This contemporary, well-produced film uses excellent graphics to explain the use and effects of crack. An excellent teaching tool, the film could lead to attitudes opposed to crack use. General broadcast is recommended.

Recommended use: With a resource person, the film would benefit people older than 11 years.

Yeah, But. . .

Number: 797.
Subject heading: Impaired driving.
Time: 27 min.
Synopsis: Max drinks with friends; after they leave, he continues. When he calls his wife to say he'll be home soon, she worries about his drinking and driving. On the way home, Max is arrested and taken to jail. There he meets other drunk drivers from whom he tries to disassociate himself. In court, the judge suspends sentence if Max attends a Driving Under the Influence (DUI) program. The DUI program director tells Max he must also attend weekly Alcoholics Anonymous (AA) meetings and abstain from alcohol. After the first group discussion about rage, Max feels better about attending the course and not drinking.

General evaluation: Poor to fair (2.8). The film generally portrays realistic situations; however, the group session is unrealistic, and positive changes in some group members happen too quickly.

Recommended use: The film could be used in impaired driving courses.

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

14th Annual Meeting of the Canadian Sex Research Forum — Sept 13-14. London, Ontario. Information: R.W.D. Stevenson, executive director, Canadian Sex Research Forum, sexual medicine unit, Shaughnessy Hospital, 4500 Oak St, Vancouver, British Columbia V6H 3N1.

Canadian Psychiatric Association Annual Meeting: Human Dimensions of Psychiatry — Sept 16-18, London, Ontario. Information: Lea C. Métivier, 225 Lisgar St, Ste 103, Ottawa, ON K2P 0C6.

Pharmacology and Drug Abuse Distance Education Course — Sept 16-Dec 16, Jan 20-April 20, 1988. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Early Diagnosis of Addictive Disorders — Sept 27, Toronto, Ontario. Information: Bellwood Health Services Inc, 1020 McNicoll Ave, Scarborough, ON M1W 2J6.

1987 Criminal Justice Congress — Sept 27-Oct 1, Toronto, Ontario. Information: Congress 87 organizing committee, 60 St Clair Ave E, Ste 600, Toronto, ON M4T 1N5.

Canadian Association of Addiction Counsellors Fall Workshop: Case Management — Sept 29, Toronto, Ontario. Information: Bill Vine, community services, George Brown College, 2 Murray St, Toronto, ON M5T 1T6.

Health Promotion: Insights and Innovations — Oct 1, Toronto, Ontario. Information: Alison Stirling, Parkdale Community Health Centre, 1257 Queen St W, Toronto, ON M6K 1L5.

16th Annual Ontario Occupational Health Nurses Conference: Capital Gains — Oct 19-23, Ottawa, Ontario. Information: Barbara Taylor, 1116 Castle Hill Dr, Ottawa, ON K2C 2A8.

Input 87, 7th Biennial Educational Symposium on Employee Assistance Programs in the Workplace: Networking and New Perspectives — Oct 25-28, Ottawa, Ontario. Information: Input 87, conference and seminar services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

Drug Education Coordinating Committee 1987 Conference, Drug Abuse: Epidemic or Smokescreen — Oct 29-30, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

Canadian Conference on AIDS Education — Nov 12-13, Cornwall, Ontario. Information: John Darbyshire, Eastern Ontario Health Unit, 1000 Pitt St, Cornwall, ON K6J 3S5.

United States

North American Congress on Employee Assistance Programs — Aug 10-13, Seattle, Washington. Information: NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, Michigan 48084.

United States National Woman's Christian Temperance Union Annual Meeting — Sept 3-7, Camp Hill, Pennsylvania. Information: Mrs K. Edgar, president, 1730 Chicago Ave, Evanston, Illinois.

National Association of Addiction Treatment Providers (NAATP) — Sept 17-18, Houston, Texas. Information: NAATP, 2082 Michelson Dr, Ste 304, Irvine, California 92715.

American Medical Society on Alcoholism and Other Drug Dependencies, Fall Review Courses for Physicians — Sept 17-19, New Orleans, Louisiana; Oct 8-10, Chicago, Illinois; Oct 22-24, San Francisco, California; Nov 5-7, Arlington, Virginia. Information: AMSAODD, 12 W 21st St, New York, NY 10010.

38th National Conference on Alcohol and Drug Problems — Sept 20-23, St Louis, Missouri. Information: Alcohol and Drug Problems Association of North America, 444 N Capitol St, #181, Washington, DC 20001.

National Association of Lesbian and Gay Alcoholism Professionals 2nd National Conference — Sept 24-27, Chicago, Illinois. Information: NALGAP, 1208 E State Blvd, Ft Wayne, Indiana 46805.

American Association for Automotive Medicine Annual Meeting — Sept 27-29, New Orleans, Louisiana. Information: Elaine Petrucelli, executive director, 40 2nd Ave, Arlington Heights, Illinois 60005.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Oct 3-7, Chicago, Illinois. Information: Thomas J. Delaney, executive director, ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

10th Annual Current Concerns in Adolescent Medicine — Oct 8-9, New York, NY. Information: Ann J. Boehme, associate director for continuing education, Schneider Children's Hospital, Long Island Jewish Medical Center, New Hyde Park, NY 11042.

American Medical Association National Conference on the Impaired Health Professional — Oct 8-11, Chicago, Illinois. Information: Janice J. Robertson, AMA dept of substance abuse, 535 N Dearborn St, Chicago, IL 60610.

American Public Health Association Annual Meeting — Oct 18-22, New Orleans, Louisiana. Information: William McBeath, 1015 15th St NW, Washington, DC 20005.

Freedom 87: The Geisinger National Conference on Addiction — Oct 28-Nov 1, Philadelphia, Pennsylvania. Information: Alan Hulsman, Freedom 87, c/o Marworth, Waverly, PA 18471.

Family Therapy Works: 45th AAMFT Annual Conference — Oct 29-Nov 1, Chicago, Illinois. Information: American Association for Marriage and Family Therapy, 1717 K St, NW Ste 407, Washington, DC 20006.

Association for the Advancement of Behavior Therapy Annual Meeting — Nov 12-15, Boston, Massachusetts. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

Abroad

4th International Conference on Treatment of Addictive Behaviors — Aug 16-20, Os (Bergen), Norway. Information: Peter E. Nathan, conference registrar, Center of Alcohol Studies, Rutgers University, New Brunswick, NJ, USA 08903 or Tor Loberg, conference registrar, Hjellestad Clinic, N-5066b Hjellestad, Norway.

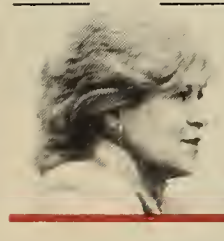
International Conference on Drug Addiction: A Multidisciplinary Analysis — Sept 7-11, San Sebastian, Vitoria, and Bilbao, Spain. Information: Secretaria del II Congreso Mundial Vasco, Paseo de la Senda, 15-bajo, 01007 Vitoria-Gasteiz, Basque Country, Spain.

Research Conference: Statistical Recording Systems of Alcohol Problems — Sept 14-18, Helsinki, Finland. Information: E. Österberg, Social Research Institute of Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland.

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Secretariat, 6th World Conference on Smoking and Health, c/o Japan Convention Services Inc, Nippon Press Centre Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.

9th International Conference of the Non-Governmental Organizations for the Prevention of Drug and Substance Abuse — Nov 23-27, Hong Kong. Information: Conference secretary, 9th NGO conference, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

Drugs move up on world political agenda



Anne MacLennan reports

VIENNA — The Pope sent opening greetings. So did the President of Bolivia and the chairman of the council of ministers of the Soviet Union.

Edwin Meese, United States Attorney-General, only rarely emerging from an apparently-appended scrum of reporters, brought a message from President Ronald Reagan and Nancy.

The Prime Minister of Malaysia and his wife, a veteran of Nancy Reagan's "first ladies' " war on drugs, were there.

So was Canada's Health Minister Jake Epp.

It was June, weeks after the Canadian government had announced its strategy on drugs, and weeks, months, and years before, and after, many other countries had done or would do likewise.

Many hundreds of people from around the globe had converged on Vienna for the eight-day International Conference on Drug Abuse and Illicit Trafficking (ICDAIT), called by the Secretary-General of the United Nations (UN).

There were senior politicians, 64 of them cabinet ministers, from 138 countries — from Algeria to Zambia, Liechtenstein to China, Zaire to Argentina.

There were representatives of more than 170 non-governmental organizations (NGOs), also from large and small dots around the globe, who held a concurrent NGO Forum.

Guiding, observing, serving, and supporting them, and representing still other agencies, organizations, and interests were somewhere between 1,500 and 2,500 others. Parliamentarians; bureaucrats and experts in health and drugs, and national and international law and enforcement; journalists (350, but only one attending from Canada); diplomats, clerks, and ambassadors; translators into and from several languages.

Away from the many concurrent meetings, in the rambling corridors of the new Austria Centre, were information specialists, promoters, marketers, entrepreneurs.

Their exhibits — from countries, states, and NGOs — lent the event the air of the biggest, high-tech trade show ever in the addictions field.

It was intended to illustrate the spectrum of approaches to drug problems — reduction of demand through education, prevention, research, treatment, rehabilitation; and reduction of supply through control and interdiction. But, the apparent emphasis was on supply reduction, exposing a burgeoning business in test, search, sniff, identify, and seize technology.

Canadian scarlet

What was true for other countries, at least developed countries, was true for Canada. Scarlet-coated Royal Canadian Mounted Police officers had only a quarter of the Canadian exhibit space but were the main attraction. Canadian second-place went to a Customs and Excise exhibit — a gas chromatography-based, portable device that can spot even minute traces of heroin or cocaine — for example, in the folds of the courier's pocket after he's made the delivery.

The exhibits provided some clues to the dimensions of the drug problem.

British officials noted, for example, that East Germans, Bulgarians, and Russians displayed keen interest in a machine made by British Aerospace that can sniff out minute quantities of drugs, or explosives (**The Journal**, August, 1986) in cargo containers. (Eastern Bloc countries tend to deny major problems of drug use but do allow they are plagued by trans-shipping.)

Of the many hundreds of participants, at all levels, some had long-standing concern about drug abuse and trafficking problems. Some, as well, had broad experience; others hadn't. Many were novices — to the field and to the international system — coerced now into involvement, if not particular interest, by political and/or bureaucratic necessity.

Only a minority were more than passingly familiar with the ailing body that brought them together.

The UN at 40 years of age is half-crippled by sustained expansion over that period in the scope, range, and volume of its work and by parallel growth in intergovernmental machinery. Having tackled emerging new problems throughout its history, it continues to face old ones still unsolved.

"Today's structure is too complex, fragmented, and top heavy," wrote a group of high-level intergovernmental experts (known as the Group of 18) after a recent review of the administrative and financial functioning of the UN.

The group's report is peppered with criticisms — with phrases such as duplication of agenda and work, unheeded recommendations for reform, poor coordination of activities both within the UN and through the system.

The report, with recommendations, has "only begun a reform process," which must now be carried further "by the intergovernmental bodies and by the Secretary-General," the authors urge.

It was against this backdrop of administrative and fiscal turmoil that Secretary-General Javier Perez de Cuellar called for the ICDAIT (**The Journal**, July, 1985).

It was in response to growing concern among many health and enforcement experts at both national and international levels about the global nature of drug problems, and the acknowledgement that many of the problems, particularly perhaps those caused by trafficking, are shared, not only by provincial communities but also by states and countries.

On the health side are the exorbitant costs of reinventing wheels — in education, treatment, prevention, even research.

The Secretary-General asked for an expression of high-level political commitment, and he got it.

Although Canadian experts have long played a significant role internationally in stressing that supply reduction alone can't work, and that equal emphasis must be placed on reducing demand for drugs, the government's political contribution to the ICDAIT was fairly typical of governments there.

As lead speaker at the opening plenary, his speech delayed by an 11th hour negotiation between Bolivia and Malaysia for the presidency (Malaysia emerged the victor), and with hundreds of speeches to follow, Health Minister Epp remained conservative of vision.

He described Canada's new strategy and added his ministerial-level voice to those of the experts, reiterating Canada's commitments to a balanced approach with emphasis on prevention, treatment, and enforcement; international action; and, providing assistance to other countries "to create a viable global front" against drug abuse and trafficking.

By the end of the meetings, two documents had been developed and approved by consensus of the governments — a political declaration of intent to work together, and a menu of program options on both demand and supply reduction — the Comprehensive Multidisciplinary Outline (CMO) [see page 1].

Priority given

Development of the new international treaty aimed at removing the proceeds from drug trafficking (**The Journal**, April) was also given priority. And, there was a range of suggested follow-up activities: a year devoted to the fight against drug abuse and trafficking; a follow-up conference; the annual observation on June 17 of an international day against drug abuse and trafficking; the establishment of a prevention resource centre under the UN.

Follow-up is officially in the hands of the Secretary-General and Director-General Margaret Anstee. The UN, in turn, and the reform process begun by the Group of 18, is dependent on the continued commitment of member states.

For Ms Anstee, that the meeting was "held at all is of tremendous significance, the thing is to get policy ministers there."

At the end, the president of the conference was hopeful.

"If the question is whether our political response has been adequate, then the answer is a resounding yes," Dr Mahathir Bin Mohamad, Prime Minister of Malaysia, said in a closing statement.

"The next important question we need to ask ourselves is whether we, as the international community, can translate our political commitment into effective and sustainable action.

"History is littered with high and grandiose pronouncements that are cast aside unimplemented."

His question is one that Canada (and other countries) faces not only at the international level, but also at home as work to translate national strategy into effective action continues.

THE BACK PAGE

National forum: heading for the future

By Elda Hauschildt

TORONTO — One hundred and twenty people from across Canada will meet in Winnipeg next month to discuss planning and implementation of drug awareness programs under the national drug strategy.

"The National Forum will be a dynamic opportunity to network, to look at issues of programming at the community level, to plan, and to begin implementation," Henry J. Schankula, forum chairperson, told **The Journal**.

Mr Schankula is director, education resources, Ontario's Addiction Research Foundation here.

"The October meeting will be hands-on, with the theme, Heading for the Future. The emphasis will be on the exchange of information and access to that information.

"Delegates will leave with a manual of pragmatic information: who the people are who are actively involved in creating and implementing regional and national programs, what resources they can access, and how they can implement programs when they get back home."

Mr Schankula is chairperson of the national working group on community action programs, one of five working groups appointed by an executive implementation committee on the national drug strategy (**The Journal**, August), as well as of the national forum.

"A number of the provincial agencies are identifying personnel who can directly and pragmatically help with development of planning and programs under the strategy.

"We at the ARF are making a major commitment to ensure the best possible implementation within our jurisdiction."

Mr Schankula suggests the main target group under the national strategy will be youth. "Their slates are relatively clean and they can be influenced to select a healthy lifestyle. By mid-life, the

(See **Prevention**, p2)

Schankula: networking

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INSIDE

Need is critical in Canada for AIDS/drug user data

By Kate Fournis

TORONTO — The problem of AIDS and AIDS virus infection in Canadian intravenous (IV) drug addicts has become a major concern to the committee advising the government on the disease.

At the same time, federal health officials are planning a study that may define how big the problem is here.

"I wouldn't want to use the word terrified, but we're really seriously concerned, because of experience elsewhere, that this is going to be a major, *major* problem," said Norbert Gilmore, MD, PhD, chairman, National Advisory Committee on AIDS (NAC-AIDS).

"It has to be dealt with fairly quickly, fairly aggressively, to prevent any further spread, if there has been any," he told **The Journal**.

Dr Gilmore also issued a plea for addiction researchers to get involved: "Drug addiction is one of the major modes of transmission of HIV, and we need to know more.

"Let's call out the troops. With all of the emphasis at the federal level on dealing with the AIDS problem and dealing with the drug addiction problem (**The Journal**, August), I think this would be a real attraction for people working in the field to get going on it."

Of the 1,099 adult cases of AIDS reported in Canada as of July 6, 1987, five were people with a history of drug addiction.

"That to us is the warning that there may be a fair proportion of people abusing drugs who are infected," said Dr Gilmore.

Estimates are that for every AIDS case reported, there are 50 to 100 times as many more people infected with human immunodeficiency virus (HIV), of whom at least half may go on to develop full-blown AIDS.

But, guesses about the extent of HIV infection — primarily based on Red Cross data on blood donors, testing in the United States military, and studies of homosexuals — may not be applicable to the Canadian population generally or other specific risk-groups in particular, Dr Gilmore said.

AIDS IV drug use

In fact, health officials have no idea what the extent of HIV infection is in the Canadian population.

NAC-AIDS members and federal health officials are planning a massive study to gather that information, which is crucial for strategic planning and evaluating the impact of AIDS education.

One approach being considered is to have physicians who see large groups of patients, such as family doctors, physicians in student health services, or doctors in employee health centres, ask patients to volunteer blood samples for the study and to completc a short questionnaire. The questionnaire would give information on whether a patient belongs to any existing or

(See **Even**, p2)

'Opening the door for infection'

Re-injection method dangerous

By Betty Lou Lee

HAMILTON — A new method of injecting illicit drugs, called preflagging, increases the risk of transmitting viral diseases like hepatitis B and AIDS.

In a variation of intravenous Talwin and Ritalin use (Ts and blues), which has shown up in western provinces, blood is withdrawn with a syringe, the drugs are mixed with it, and it is reinjected, says Kevin Fehr, PhD, a former Addiction Research Foundation, Toronto, research scientist.

Dr Fehr, a pharmacologist, says there is no physiological reason why this procedure would give an increased drug effect. And, thc reinjection of blood opens the door for infection, particularly if syringes are being shared.

Talwin is pentazocine, a non-narcotic prescription analgesic, and Ritalin is methylphenidate, an amphetamine-like stimulant. Dr Fehr speculates the mixture's effects (**The Journal**, March) may be similar to the mixture of heroin and cocaine that some drug abusers use.

Fehr: developments

Speaking at the 28th annual Institutc on Addiction Studies at McMaster University here, sponsored by Alcohol and Drug Concerns, Inc, Dr Fehr outlined some new developments on the illicit drug scene:

- One western Canadian mother had coached her normal, 12-year-old son to mimic hyperactivity when in doctors' offices, to get prescription Ritalin she could sell on the street.
- Anorexiants or diet pills are less potent than they were in the early 1970s and are not common on the street, but use of high doses of them can lead to paranoid episodes and violent outbursts, Dr Fehr, now with a pharmaccutical company, said.
- Over-the-counter dccongestants used in high doses can give amphetamine-like effects. School children are paying $1 to $2 each for such pills, called beans, bennies, or black beauties, and street-marketed as amphetamines.
- A recent advertisement in a popular drug-culturc magazine shows a bikini-clad couple bored "beforc" and active "after" taking energizers, being sold for five cents a capsule if 3,000 are ordered. In print, "so fine you'd pretty well have to have a magnifying glass to rcad it," the contents are idcntified as 350 milligrams of caffeine — the equivalent of four cups of coffee, Dr Fehr said.

Manitoba's programs to go under microscope

By Maureen Brosnahan

WINNIPEG — The Manitoba government is planning a major review of all its drug and alcohol programs.

Health Minister Larry Desjardins said it's the first time in 13 years that such a review has been conducted here.

Mr Desjardins said that although Manitoba spends millions of dollars annually on alcohol and other drug programs, throwing more money at the field is not the only answer.

Complete details of the review and who will conduct it have not been released. But, Mr Desjardins said, it will assess the scope and degree of alcohol and other drug use and examine provincial policies, legislation, and delivery of services. The review will also present specific strategies and recommendations to improve the system.

The chairman of the Alcoholism Foundation of Manitoba (AFM), Provincial Court Judge Charles Rubin, said the AFM has been urging the government to conduct a review for some time and it is long overdue.

With a $9 million annual budget and its mandate to control and direct almost all the funds the province puts into alcohol and other drug programs, the AFM will come under close scrutiny. But, Judgc Rubin said thc rcview is necessary: "An outside look would bc helpful to set new policies and directions for thc decade . . . you sometimes gct a little incestuous when you're thc biggest player in the game."

Judge Rubin expects the review to includc input from community groups, parents, and drug users as well as groups such as the policc and medical professionals in the addictions field. He said a wide-ranging review is one way to ensure "fresh ideas" in thc community are uncovered.

The review will take about six months to complete.

Rubin: 'biggest player'

NEWS

Briefly . . .

Orchids, not opium

OSLO — A campaign by Swedish Good Templar organizations to sell 600,000 orchids imported from Thailand will have a two-pronged effect. The funds raised will go to support development programs in the Thai opium-poppy growing areas, and an information and education program will help create awareness among Swedish youth of the problems of drug use and illicit trafficking.

Dad's a danger too

LONDON — Babies of passive smokers may be in more danger than babies of smoking mothers. Research at Surrey University suggests babies born to non-smoking women who live with someone who smokes more than five cigarettes a day weigh less at birth than infants of non-smokers and less than infants of smokers. A link has also been found between passive smoking and deficiency in zinc, reports the London *Sunday Times*.

Age law works

NEW YORK — Alcohol use and problems among young people have dropped significantly since the purchase age was raised to 21 years, says a study by the State Division of Alcoholism and Alcohol Abuse here. For youths aged 16 to 20 years, alcohol purchases dropped by 56%; consumption fell by 20%; drinking to intoxication dropped by 33%; and, driving after drinking decreased by 21%, says a report in *The Bottom Line on Alcohol in Society*.

Royal patron

LONDON — The Princess of Wales has pledged her support of anti-drug efforts by becoming patron of Turning Point, England's largest substance abuse charity with more than 30 centres nationwide. Princess Diana last year presented a special recognition award to one of Turning Point's centres, says *Alliance News*.

AIDS conception

LONDON — Women conceiving by artificial insemination may have a new worry, contracting AIDS. Britain's chief medical officer has issued an urgent warning to artificial insemination clinics here saying they should refuse sperm donations from homosexuals and bisexuals, "mainline" drug abusers, hemophiliacs, and those from countries where AIDS is common, reports *Doctor*. Professor John Dennis says all sperm donors should be screened.

No, not booze

WASHINGTON — News media have been urged by the Distilled Spirits Council of the United States (DISCUS) not to use the word 'booze' when referring to alcohol, as it suggests excessive drinking. In fact, says a DISCUS pamphlet, *A Reporter's Guide to the Liquor Industry*, they'd rather the media avoid calling beverages 'alcoholic' since that too has a negative connotation. Instead, they recommend 'alcohol beverages' or 'bev/al' which "provide a more positive public image."

Little 'crack' being seized: police

By Betty Lou Lee

HAMILTON — Increased activity against drug smuggling in the United States has led to increased availability of cocaine in Canada and a drop in its price.

Sergeant Ben Jenkins, Royal Canadian Mounted Police drug awareness program, says the kilogram price has dropped about 60% in the past year.

"Last year, a kilo would cost about $800,000," he told the annual Institute on Addiction Studies held here by Alcohol and Drug Concerns, Inc. "This year, if you're lucky, you could get it for $300,000, there's so much of it around."

Because of increased police surveillance and enforcement in areas like Florida, drug marketers in Colombia are now turning to Canadian entry points. They then ship the drug south, he said, and that's the reason for the large amounts seized in recent arrests.

He added that there were only nine or 10 seizures of crack in Ontario last year, and it doesn't appear to have widespread use (The Journal, August, 1986).

Publicity about its hazards and addictiveness, particularly after the death of some young athletes, has probably had an impact, Sgt Jenkins suggested.

He predicted the next major drug problem will be among the elderly — abusing alcohol and prescription drugs (The Journal, February, 1986) — and that the dimensions of the problem will grow as the population ages.

"They get past retirement age, friends pass away, and, especially if the spouse dies, they stay at home. The kids don't visit, they start having a drink watching the soap opera, then they have two or three more."

Many inadvertently discover they get a better effect if alcohol is combined with some of their prescription drugs, he added.

Manitoba group follows Ontario program

Pharmacists filling prevention Rx

By Maureen Brosnahan

WINNIPEG — Manitoba pharmacists are launching a program to promote public knowledge of drugs and their potential dangers.

Called *Know Drugs*, the program is based on a similar project in Ontario, said Ron Guse, program coordinator and deputy registrar of the Manitoba Pharmaceutical Association (MPhA).

Golobitsh

When to say no: pharmacists' expertise being promoted

Mr Guse said although there are plans to expand the Ontario program — known as Pharmacists Against Drug Abuse (PADA) — across Canada, the MPhA wanted to proceed immediately.

The program will encourage schools and service clubs to call on their local pharmacists' expertise, encouraging pharmacists to speak to various groups about their particular interests and concerns about drugs.

"We're telling people they should know about the drugs they're using, and when to say no," Mr Guse said.

He said information booklets are being printed and the program will be in full swing this fall with the support of the pharmaceutical association and other groups such as the police.

He said the police often conduct their own public seminars and, while they can inform people about the street scene, they don't have the expertise to talk specifically about the drugs and how they work. That's where the pharmacists can help.

"It's a team approach. We see the good drugs can do in keeping people alive, but we also see the harm they can do."

Mr Guse said the cost of launching the program is minimal; funding for the booklets will be covered by the pharmaceutical association. A Winnipeg pharmacist, Myron Kurewicz, has volunteered to help coordinate the effort.

The Alcoholism Foundation of Manitoba has also offered its support, agreeing to critique the program and provide suggestions for improving it once it gets underway.

Unions/management say no screening

HAMILTON — Mandatory or random drug testing has no place in Canadian workplaces, even for safety reasons, a group of senior management and union executives and occupational physicians has told the federal, provincial, and territorial governments.

Pre-employment testing, however, found the group divided; labor and occupational physicians were against, and management wanted "strongly to preserve its right to protect itself in the hiring process."

The Canadian Centre for Occupational Health and Safety here recently published conclusions of an across-Canada workshop group.

Recommendations have been sent to Health and Welfare Canada, Transport Canada, and to ministers and deputy ministers responsible for health and safety in the federal, provincial, and territorial governments.

The group said testing will not solve the drug abuse problem and does not measure performance or ensure safety.

Any testing for just cause (based on deteriorating performance) should be jointly agreed to by labor and management and must be for the health and welfare of employees.

"Joint labor-management employee assistance programs must not be undermined by close association with drug testing; one is constructive, the other is punitive," the group concludes.

The group also agreed that further discussion is needed on pre-employment drug testing.

Even without AIDS, 'tough' to handle drug population

(From page 1)

emerging AIDS risk groups.

Such an approach might be a good springboard for studies of drug abuse in general, as well as for AIDS-related research in IV drug addicts (**The Journal**, July), Dr Gilmore said.

"A sero-prevalence study would be useful because it might tell us, at least in crude terms, how many people might have abused drugs recently, and then by inference, what proportion of those people might have become infected because of that.

"Researchers may then want to launch specific studies on the drug-addict population itself.

"These people not only have a problem with their immune system, but also a problem with substance abuse and the consequences of that. You put HIV into the group that abuses drugs — a population which is tough to deal with at the best of times — and you've got a real mess on your hands."

Prevention geared to youth

(From page 1)

wealth of experience people have reinforces behavior, and it's harder to get people to change.

"With youth, if you provide genuine, factual information in terms of drug use, in terms of effects, and in terms of alternatives, you can direct people to more positive goals.

"And, you get the biggest bang for the buck, in terms of preventing later health problems."

Mr Schankula emphasizes that community action programs will be more than "just money programs. There will be program money too, but we will emphasize personal commitment and energy. We want to change the attitudes of significant people in the community — teachers, parents, people who function as role models for youth.

"We want to change how the media portray the world of drugs, how business — both legal and illegal — reflects the availability of various products, and how the community can respond in providing substitute programs and alternative behavior activities.

"All of these activities have to be part of any program against drug abuse."

NEWS

Ontario group backs education, rehabilitation

Prohibit mandatory drug testing, lawyers say

By Joan Hollobon

TORONTO — Mandatory drug testing by employers should be prohibited by law, the Ontario division of the Canadian Bar Association recommends after study by a broad-based committee appointed a year ago.

Rather, Canadian governments at all levels should support educational and rehabilitation programs; they are likely to be far more effective than mandatory drug testing, the report says.

The report cites examples of successful, confidential, on-the-job rehabilitation programs, supported by unions and co-workers, often working alongside programs designed to reduce workplace stress.

The Canadian Bar Association-Ontario (CBAO), representing some 15,000 Ontario lawyers, judges, and law students, initiated the study because mandatory drug testing in the workplace "is fast becoming one of the most significant and contentious issues in management/labor relations in Canada as well as in the United States."

Mandatory drug testing (**The Journal**, March, 1986) reverses the usual presumption of innocence by viewing all workers as guilty until proven otherwise, the report notes.

Application of particular sections of the Canadian Charter of Rights and Freedoms has yet to be judicially determined. Most likely, mandatory drug testing will be considered a "search and seizure" (**The Journal**, September, 1986); the critical issue is whether it will be judged to be "unreasonable" and therefore in violation of the charter.

Several major pitfalls of testing were noted in the report:

- Tests often fail to distinguish between legal drugs, such as antihistamines, and illegal drugs and may even give false positive results from foodstuffs, such as poppy seeds, herbal tea, and cranberry juice (**The Journal**, May).
- Tests can be unreliable in the absence of stringent quality control.
- Testing cannot distinguish between heavy, chronic abuse and a one-time experiment with a drug.
- Tests do not provide evidence of impairment or predict a worker's ability to do the job.

Ways of foiling tests are continually being devised, leading to increasing invasion of privacy, such as strip searches and "direct observation," to ensure the urine sample comes from the individual under test and has not been tampered with.

Toronto lawyer Sandra Chapnik, committee chairman, told a press conference: "People who are drug or alcohol dependent will find ways to avoid detection."

Refusal to submit to mandatory drug testing usually carries a "presumption of guilt and results in termination of employment." An exercise rider at a Toronto racetrack "was subject to termination" because of refusal, despite 19 years of satisfactory work. In Georgia, a woman who did not use drugs lost her job and could not get another in her community because she refused a test.

The report also cites the suicide of Canadian jockey Dan Beckon after he tested positive for cocaine on three occasions. The drug-testing policy of the Ontario Racing Commission, begun in October, 1986, "does not require the employer to have reasonable suspicion of abuse or evidence of inadequate job performance before testing an employee."

Ontario's Addiction Research Foundation last March recommended that mandatory pre-employment and employment drug testing should be considered when the safety of the public or other workers is involved (**The Journal**, April).

The CBAO committee, however, said public safety is hard to define: an employer might consider the potential for a chemical spill a threat to public safety, while a patient might feel he has a right to ensure that operating room doctors and nurses are drug-free.

In considering pilots or public transit drivers, the question becomes when to test. "An airline pilot, for example, would have to be tested at each stop or on reporting for duty, then strip-searched, and sealed in the cockpit."

In Canada, there has been little evidence of drug-related, workplace accidents. Questionable workplace safety measures sometimes prove much more significant.

Society should be concerned not only with the results of drug abuse, but also with its causes and the economic, social, psychological, and physiological factors involved. Significant expansion of prevention, education, and lifestyle training in schools, media, and workplaces is needed.

"Alternatives to alcohol and drugs should be promoted. Once our cultural standard is altered, the social pressures to conform will adapt themselves to a new and different standard of behavior," the report concludes.

Support group to expand

TORONTO — The Canadian Bar Association (CBA) is considering a strategy for a nationwide program to help lawyers with alcohol-related problems.

Programs already exist in Edmonton, Calgary, Winnipeg, and Montreal. However, the only province-wide program is the Ontario Bar Alcoholism Program (OBAP), endorsed by the CBA-Ontario and the Law Society of Upper Canada.

The OBAP is entirely independent of the official law bodies, and all help is confidential.

The OBAP plans to extend its program through seminars for law schools, the bar admission course, and local bar associations to increase understanding of alcoholism.

Alcohol is a major factor in about 80% of the cases dealt with in both criminal law and family law practice, says OBAP chairman, John R. Campbell.

Prevention patrol for police chiefs

By Joan Hollobon

WINNIPEG — Better and more consistent training about drugs for school-liaison police officers is top priority of a new drug abuse committee formed by the Canadian Association of Chiefs of Police.

The committee chairman and vice-chairman are Chief Herbert Stephen of Winnipeg and Chief Superintendent Rodney T. Stamler, Drug Enforcement Directorate, Royal Canadian Mounted Police, Ottawa.

Chief Stephen told **The Journal** the association is concerned that Canada's drug problem "seems to be on the increase, and we are finding school children are getting involved with drugs at a younger age."

Most police departments have officers going into schools, but every department handles school-liaison programs differently, he said. The committee plans to produce a book and a video tape for distribution across Canada to help educate school-liaison officers.

Chief Stephen said the committee's third meeting was held during the annual convention of the Association of Chiefs of Police at Quebec City in late August.

Access improved

TORONTO — Selected articles in The Journal are now listed in the health section, *Canadian Periodical Index*.

The author, subject, and corporate name index is published by Info Globe, the electronic publishing division of *The Globe and Mail*.

The Journal is indexed in The Canadian Periodical Index

CPI

US treatment caught in cost squeeze

By Harvey McConnell

NEWPORT, Rhode Island — Drug dependency treatment is being caught in the cost-containment squeeze in United States medicine caused mainly by increasing use of costly technology.

And, concern about rising costs of general health care plays right into the hands of "those who have never wanted to pay for alcoholism treatment anyway," claims John Wallace, PhD, director of treatment, Edgehill Newport Foundation here. Yet, costly technology is used to prolong life with heroic measures for those "who die very expensive deaths."

Alcoholics and alcoholism are again being stigmatized by some, and arguments have revived that alcoholism is not a disease but a result of "willful misconduct." Dr Wallace said one hears more and more of workers being fired who relapse after a single course of treatment.

He says, "It is time we all stopped falling into the trap of attempting to provide single-outcome statistics representative of all people in treatment."

Instead of asking if alcoholism treatment is effective, it should be asked, effective for whom? — he told the Northeastern Conference on Alcoholism and Drug Dependence here.

Many programs can work for socially stable alcoholics whose treatment is uncompromised by negative social and environmental factors. In a six-month follow-up, Dr Wallace and colleagues found 65% had been continuously abstinent and 75% currently abstinent.

On the other hand, for the socially unstable, "we are going to have to do a lot more than treat their alcoholism. This means for some patients, we have to pay attention to such things as job training, social skills, and employment counselling."

Resolving cultural issues basic to Native rehab

'We try to help them live for today:' counsellor

By Betty Lou Lee

HAMILTON — Building self-esteem is a factor in any addictions recovery program.

For the Native population, awareness of cultural identity can be an important part of establishing a new personal identity, says Native counsellor Harold Ashkewe of Pedahbun Lodge in Toronto's Parkdale district.

"When you live your own culture, you have it in your heart: self-esteem, confidence, love, with no room for hate. Our main focus is respect for nature, for human beings, for everything around us."

The lodge's program, which serves 17 residents who stay a minimum of four months, includes the usual counselling modalities. But, it also includes a morning ceremonial in which the traditional purifiers — sweet grass, sage, tobacco, or cedar — are burned.

"It helps (people) get rid of negative thoughts and be more positive," Mr Ashkewe says.

"Many of our clients have a lot of bitterness; they were forced to leave their families (to go to residential schools or institutions). We try to help them understand, to accept what happened, and to live for today. . . . Many of them lost their identity through children's aid societies and institutions.

"They knew they were Native, but not what it means. . . . It was not discussed."

Many Natives were not allowed to speak their own languages; they were forced to cut their hair so they couldn't wear braids, a symbolic reminder of the trinity of mind, body, and soul.

Mr Ashkewe was raised in an addictive family: "I was five years old the first time I was drunk; I don't feel too good about it."

He was a client of the lodge five years ago. "I had taken the treatment, and it's important to give something back."

Clients are encouraged to seek out elders and teachers to continue their cultural understanding.

"Part of being Native is securing and maintaining the family concept, from youngest to oldest."

Mr Ashkewe was one of about a dozen Native counsellors attending the 28th annual Institute on Addiction Studies held here at McMaster University by Alcohol and Drug Concerns, Inc.

Ceremonies: helping get rid of negative feelings

NEWS

RESEARCH UPDATE

Cocaine and endocarditis

Intravenous (IV) cocaine users appear to be more at risk for endocarditis than people who intravenously use other drugs. Endocarditis is a heart infection seen relatively frequently with IV drug abusers but not previously linked specifically with IV cocaine abuse. The link was made by researchers at San Francisco General Hospital and the University of California, San Francisco, using data on 102 IV drug users. The patients were admitted to the hospital in 1981 for the evaluation of fever, to rule out endocarditis, or for a complication related to drug use. Bacterial endocarditis was diagnosed in 23 of the 115 hospitalizations (20%), and analysis showed an unexpectedly strong association between cocaine use and endocarditis. In fact, use of the drug was the strongest predictor of the disease. The finding was collaborated by another ongoing study by the researchers, which found that of 39 patients with endocarditis, 30 had used cocaine either alone or in combination with heroin. Speculating on the reason for the link, the researchers include these possibilities: different usage patterns, differences in the bacterial flora involved, or the direct effect of the cocaine itself.
Annals of Internal Medicine, June, 1987, v.106:833-836.

Smoking risks calculated

As many as one-third of heavy smoking, 35-year-old men will die before age 85 years from smoking-related diseases. Researchers from the United States National Cancer Institute also say the public should be made more aware of the specific, concrete risks smokers face. To calculate the probability of death from smoking at various ages for light and heavy smokers and for ex-smokers, the scientists used mortality data from prospective studies in the 1950s and 1960s. These were scaled to 1982 mortality levels. Age-specific death rates in 1982 for all smoking-related diseases were available to them from the US National Center on Health Statistics. To estimate the probability of dying of a smoking-related disease, nine life-tables were constructed for each disease category (lung cancer, coronary heart disease, and all smoking-related diseases) in each of the three smoking status categories. The tables show a 35-year-old man who smokes 25 or more cigarettes daily has more than a 6% chance of dying of lung cancer due to his smoking before he reaches 65 years and an 18% chance of doing so before age 85. For all smoking-related diseases, those figures are 16% and 36% respectively.
American Journal of Public Health, April, 1987, v.77:425-431.

CAGE nets abusers

One of the simplest tests of potential alcohol abuse has proven more effective than biochemical tests or physician screening. Responses to the CAGE questionnaire (a mnemonic for four questions dealing with attempts to Cut back on drinking, being Annoyed at criticisms about drinking, feeling Guilty about drinking, and using alcohol as an Eye opener) were scored in a prospective study of 518 patients admitted to the orthopedic and medical services of Boston's Beth Israel Hospital in a six-month period. In addition to the CAGE questions being asked within a general 25-question interview, biochemical screening tests for heavy alcohol consumption — mean corpuscular volume, liver transamthase, and gamma-glutamyl transpeptidase analyses — were performed. Detection of alcohol abuse by physicians was determined by interviewing the physicians and reviewing patients' records. Diagnostic interviews to classify patients' alcohol use were undertaken, using the Michigan Alcoholism Screening Test (MAST), with all patients who answered at least one CAGE question affirmatively, as well as with a third of the patients who scored negatively. The five Boston researchers found that the CAGE questionnaire had a sensitivity of 85% and a specificity of 89% in detecting alcohol abuse or alcoholism (as defined by DSM-III criteria) among the study group, 20% of whom were identified as being alcohol-dependent or alcohol abusers. The CAGE questionnaire had a predictive value of 62%; in contrast, the biochemical tests had a positive predictive value of only about half that. Only 27% of the alcohol abusers and 79% of the alcoholics were detected by their attending physicians. The researchers say that if used routinely, the CAGE test "offers the promise" of substantially raising the identification rate of alcohol abusers.
The American Journal of Medicine, February, 1987, v.82:231-235.

Vitamin B_{12} levels and alcoholic hepatitis

Plasma vitamin B_{12} levels are a good indicator of the severity of alcoholic hepatitis, researchers at the New Jersey Medical School have shown. With the United States Veterans Affairs Co-operative Study Group on Alcoholic Hepatitis — six centres studying the disease — the researchers showed that increased B_{12} plasma titres correlate with liver damage, while decreasing titres signify remission of disease. The study involved 370 patients with alcoholic hepatitis and a control group, in whom plasma B_{12} levels were estimated. Standard liver function tests (bilirubin, cholylglycine, and alkaline phosphatase levels) were also performed. The researchers found a good correlation between B_{12} levels and disease severity. While a normal plasma B_{12} level is associated with a 2% mortality risk with these patients, a B_{12} plasma level on admission of above 4,000 picograms per millilitre predicts a 67% mortality risk. Finding that B_{12} titres rise as death from alcoholic hepatitis approaches led the researchers to conclude that measuring the B_{12} level in the liver could provide an unambiguous test of the efficacy of interventions aimed at inducing remissions.
Alcohol and Alcoholism, no 1, 1987, v.22:1-5.

Pat Rich

Mail-in survey results in BC

Public backs alcohol rules

By Eleanor LeBourdais

VANCOUVER — A mail-in survey of 4,500 readers by the *Province* newspaper here suggests British Columbians don't want liquor sold in their grocery stores.

The respondents also suggest:

- British Columbia's legal drinking age be raised to 21 years from 19.
- sale of liquor remain under government control and not be privatized because privately owned liquor stores would likely raise purchase prices,
- the number of liquor stores be limited, and
- it is acceptable for the government to profit from the sale of alcohol.

(The BC government netted some $420 million from liquor sales in 1986.)

Nearly half of the respondents were against sale of liquor on Sundays, while 53% said sales of liquor at private outlets would lead to greater alcohol abuse. Only one in 10 advocated sale of liquor in convenience stores, and 16.5% suggested they would like beer, wine, and coolers available in corner stores. One-third suggested beer, wine, and coolers be sold in supermarkets.

The newspaper's findings contradict those of customer surveys by retail stores. More than 70% of customers interviewed by Canada Safeway grocery stores and the 7-Eleven chain of convenience stores around BC indicated they favored sale of BC wines in their outlets.

Canada Safeway spokesman Don Bell says the newspaper's survey results may not represent general public opinion. "The kind of people who respond to a write-in survey are those who feel very negatively about an issue."

Kids' drug use under study

VICTORIA — British Columbia Health Minister Peter Dueck has launched a survey in response to suggestions that drug use among students here is on the increase.

At a cost of $200,000, the province-wide probe will study alcohol and other drug use by 16,000 students attending 150 secondary schools. Survey results will be used to determine the extent of drug use and could result in additional funding for existing counselling services or the introduction of peer-help programs.

While results of the survey will be made public, they will not be broken down by school district or individual schools. The health ministry says such publicity might discourage districts or schools from participating.

The health ministry's last analysis of drug use (1982) among students in Vancouver, showed four out of 10 had used marijuana, seven out of 10 had used alcohol, two in 10 had tried hallucinogens, and only one in 10 had tried cocaine.

Local authorities suggest changes in drug popularity will probably show significant increases, particularly for cocaine.

Smoking staffers send clients signal

Nicotine: affecting treatment role

NEWPORT, Rhode Island — People who treat the chemically dependent should look at their own behavior if they are smokers to see how this affects their role.

Although he doesn't want "to be a smoker abuser," there is no question "nicotine is the drug of entry into the world of mind-altering chemicals," and "cigarette smoking is the chief avoidable cause of deaths in this country," says Max Schneider, MD, consultant, St Joseph Hospital, Orange, California. Dr Schneider is immediate past president of the American Medical Society on Alcoholism and Other Drug Dependencies.

Dr Schneider: "We need, as addiction specialists, to look at what our roles are for our clients. If we don't look at that, we are not very moral or ethical."

He said this includes looking at attitudes about smoking cessation.

Dr Schneider added that among his counselling staff, the number of smokers has dropped to two from 28, even though he has not forced the issue. Families in therapy are involved in programs about non-smoking.

WHO urges immediate action:

Smokeless tobacco threat

By Thomas Land

GENEVA — An influential group of medical experts meeting here under the aegis of the United Nations has called on governments to stamp out smokeless tobacco.

New Zealand, Israel, and Ireland have already prohibited the use of certain forms of smokeless tobacco products that are chewed, dipped, or just left in the mouth between the gum and cheek. In North America, there are more than 12 million users, a third of them under the age of 21 years (**The Journal**, March, 1986).

Most snuff is the preferred form used in the United States and Sweden, where 35% of males from 16 to 24 years use it.

Gregory N Connolly, director, dental health, department of public health, Boston, was chairman of the expert conference sponsored here by the UN World Health Organization (WHO).

Dr Connolly: "If countries do not act now, tens of millions of children could become addicted to smokeless tobacco, and many will develop oral health problems — including oral cancer."

After looking at Western Europe and North America, he said, the experts sought "to alert governments to the irresponsible marketing of these tobacco products to young people and to urge health authorities to launch programs to eradicate, or to prevent, the use of smokeless tobacco.

"We must act now to prevent the epidemic from spreading. We must not repeat the mistakes which have led to the massive health problems caused by cigarette smoking."

The meeting here was attended by experts from Western Europe, North America, Australia, and several Asian countries — where the habit has an established tradition and there are more than 100 million users.

The experts accused the tobacco industry of promoting smokeless products "cynically and aggressively despite their known harmful effects on health." They call on all countries still untouched by the habit to introduce, as a matter of urgency, "a pre-emptive ban on the manufacture, import, and sale of smokeless tobacco products before they are introduced into the market."

Other recommended measures include: compulsory health warnings, bans on advertising and sales promotions, strict prohibition of sales to children and adolescents, and public education.

NEWS

Reclaiming troubled workers: General Motors works it out

By Betty Lou Lee

HAMILTON — Sickness and accident benefit payments fell more than 80% in three years for a group of General Motors employees treated under a substance abuse program run by the company and the union, the United Auto Workers.

One group of 104 treated employees had 182 sickness and accident claims the year before treatment, 99 the first year after, and 29 the second year after. Days lost from work dropped to 1,779 a year after treatment from 3,440 a year before treatment. The next year, the total was 624.

Workers' Compensation Board (WCB) claims were 15, 11, and 6 respectively in the three years; WCB benefits fell by almost two-thirds, and days lost due to these claims went to 98, from 115, from 320.

But, for 48 employees with alcohol and other drug abuse problems who refused treatment, sickness and accident claims rose 19% in the next year, days lost increased 121%, and benefits paid rose 128%. WCB claims went up 25%; days lost and benefits paid under those claims both rose 77%.

The figures were presented here to the 28th annual Institute on Addiction Studies, McMaster University, held by Alcohol and Drug Concerns, Inc.

Edward Malloy of Oshawa, past chairman of the program, said two-thirds of employees who have taken the program have been successful. About 3,000 have participated, in its 15-year history.

Mr Malloy estimates at least 10% of employees have an addiction problem, and with 95% of them, it's alcohol.

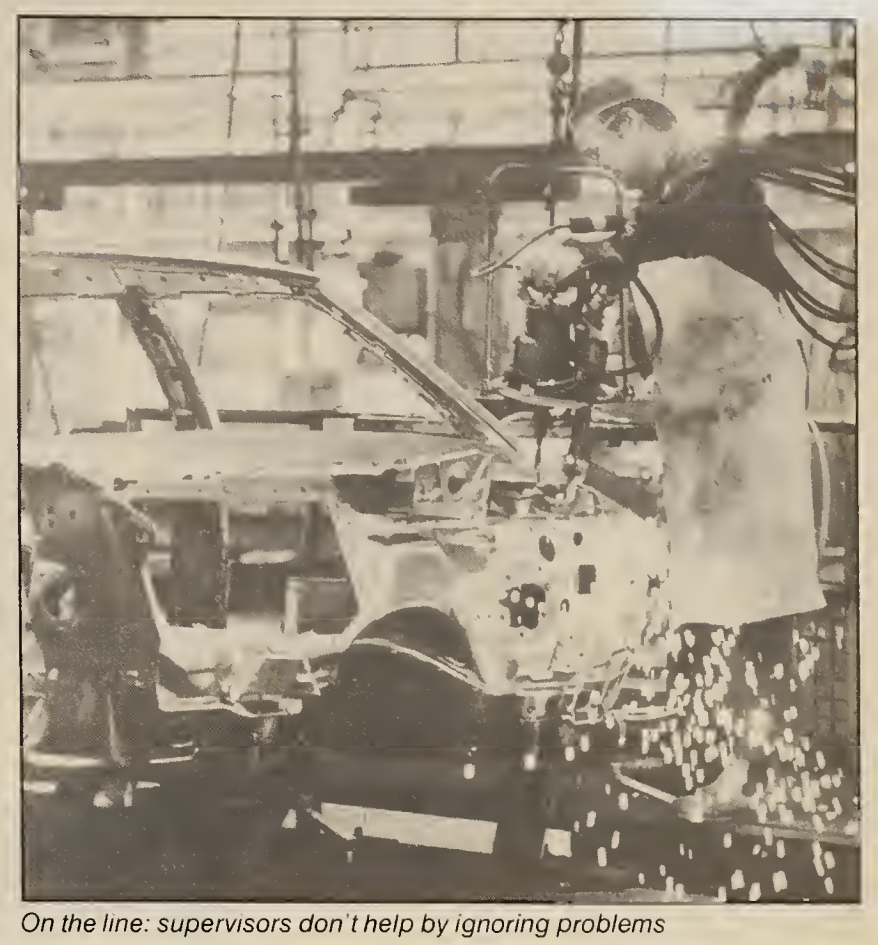
"Other drugs may account for only 5%, but that's still a big problem. There may be a lot we're not finding."

Average age of those entering the program has dropped to 32 years from 45 years when it started; 37% are under 25 years.

Not only are employees being spotted earlier, but also they realize their jobs aren't in jeopardy if they accept treatment. They trust the confidentiality of the program, Mr Malloy said.

The program is available to all family members covered by the benefits package and to retirees.

Supervisors aren't helping alcoholics near retirement by giving them easier jobs, covering up for them, or ignoring their problems, Mr Malloy said: "If he goes out of the plant with a drug or alcohol problem, then he's got eight more hours a day to devote to it."



On the line: supervisors don't help by ignoring problems

Public help essential to drug-trafficking control

By Deana Driver

SASKATOON — Progress in handling the complex problems of drug trafficking and abuse in North America will be made only if the public and enforcement officers work together to reduce both demand for and supply of drugs.

Law enforcement officers cannot do the job alone, say Ron Hollingshead, special demand-reduction agent, United States Drug Enforcement Administration (DEA), and Inspector Joseph (Neil) Pouliot, Royal Canadian Mounted Police officer in charge of national and international drug operations. They spoke to the PRIDE Canada (Parent Resources Institute for Drug Education) conference.

Pouliot: multi-faceted approach

Mr Hollingshead said if it is left to officers to stop drug abuse, "then we've lost the war."

Hollingshead: work in tandem

Enforcement officers work to stop drug supply, and resources in that area have never been better, he said. But, it is up to the public to stop the demand.

"We have to work in tandem, or I don't think there's a prayer of beating it."

Insp Pouliot said the drug problem in Canada is "highly complex. Any country that wants to effectively curb drug trafficking and drug abuse must do so in terms of a comprehensive, multi-faceted approach.

"In the short-term, we must continue to place heavy emphasis on enforcement in supply reduction programs. In the long-term, we must develop education and treatment programs that will significantly reduce the demand for illicit drugs in Canada."

The DEA has created a new field system of 23 investigators, plus support staff, to work across the US in demand reduction. Mr Hollingshead is one of the officers working in Washington, DC. He said the section is a priority of the US administration and should be ready to begin work by October.

The RCMP is also expanding its role in demand-reduction education.

Adult COAs flitting through 'grasshopper lives'

By Betty Lou Lee

HAMILTON — The legacy of adults who grow up in addictive family systems may be "grasshopper lives," says a California counsellor of adult children of alcoholics (ACOAs).

"They have cars, clothes, careers; they seem to have it all," Rae Ellen Holland told the 28th annual Institute on Addiction Studies held here by Alcohol and Drug Concerns, Inc.

"They've tried all the drugs. They change jobs, they move, they take one degree after another. They're like grasshoppers.

"They're not addicted or in a chemically-dependent relationship. But, they are not happy; they're empty. They can't maintain relationships. They can't decide if they want children — they have difficulty parenting themselves.

"They move in and out of relationships, looking for but never finding the perfect one. They came out of families where inappropriate choices were made, and they never learned how to make choices" (**The Journal**, February).

ACOAs do well in jobs with well-defined rules and regulations — like the military, police, and civil service — Ms Holland said, because they came out of families with no consistent rules. As one man put it: "Every time I figured out the rules, mother changed them."

Ms Holland's main message is that ACOAs, co-dependents, and addicts each need a separate recovery program because each has his own issues for recovery.

"You can take the drug out of the family, but there is still the mindset, the confusions, the lack of trust. . . . Take out the drug, and spouses, parents, and kids are left with an addiction to chaos."

Holland: 'Everytime I figured out the rules, mother changed them'

Delineation of ACOA problems, Ms Holland said, began with a Santa Barbara, California, group in the early 1980s and led to the National Association of ACOAs which now serves as an advocacy group.

It is preparing television public service announcements that will feature celebrity ACOAs and will hold a national convention in New Orleans in early 1988.

"They recognize the need for treatment and the need to talk. They see it as preventive mental health."

Ms Holland said the rage that ACOAs carry is "unbelievable," and it can be directed against the co-dependent, usually the mother, as well as the addicted parent.

"They perceive the co-dependent as not protecting them, as the re-enforcer who allowed the abuse (mental, physical, or sexual) to go on."

When one daughter told her mother about the father's sexual abuse, she was told "it didn't really happen, or it wasn't that bad." She wondered how she could trust her perceptions when she had been told they weren't real.

The co-dependent may also have such a high tolerance for dysfunctional behavior that she doesn't know what's normal, and neither do the children.

In a normal family, as stresses and problems arise, the children are given tools to deal with them; as they grow, boundaries are set and held, Ms Holland said.

In the addictive family, the same problems come up again and again. "It becomes normal, and the kids don't even try to avoid them. Take them out, and they will have withdrawal."

Ms Holland said ACOAs "need to know the family was diseased in its thinking, or they will reproduce the same thinking. We're now seeing ACOA kids who have been scripted the same way."

Coordinator of the Step-Ahead project, Merritt Peralta Institute, Oakland, California, Ms Holland is a therapist in an inpatient program for co-dependents and ACOAs.

New society seeks members

BERKELEY, California — The Kettil Bruun Society for Social and Epidemiological Research on Alcohol has been formed; individuals may apply for membership.

The objectives of the society are to promote social and epidemiological research on alcohol and to foster a comparative understanding of the social aspects of alcohol use and problems.

Kettil Bruun, PhD, for whom the society was named, was director of the Finnish Foundation of Alcohol Studies for 25 years. His work, including that on alcohol and drug policies and control issues (The Journal, April, 1986), was internationally known; he died in 1985.

The society's activities will include: promoting the spirit of international cooperation; acting as a medium for comparative projects on the social aspects of alcohol use and alcohol problems; and, organizing regular general meetings.

The society has elected officers: Robin Room, president; Klaus Mäkelä, vice-president; Sally Casswell, Irmgard Eisenbach-Stangl, Norman Giesbrecht, Tom Harford, Denise Herd, Jacek Moskalewicz, Esa Österberg, Eric Single, and Ole-JØrgen Skog, coordinating committee members.

Scientists working on problems related to social and epidemiological research on alcohol are eligible for regular membership. Others interested in the society's objectives are eligible for affiliate membership.

Inquiries should be directed to: Kettil Bruun Society, Alcohol Research Group, 1816 Scenic Avenue, Berkeley, California 94709.

Bruun: remembered

LETTERS

'Great style,' 'special appreciation'

Inside Out wins readers' praise

I have been an avid reader of **The Journal** for years, while working at Tucson General Hospital. I left the hospital in February, 1987 to work for the Tucson Osteopathic Foundation.

While waiting to have my subscription switched over, I missed the March and April issues. Is there any chance of my receiving those issues, as I find every issue a valuable source of information.

If for some reason you cannot forward these to me, may I impose on you to send a copy of the Inside Out column for each issue?

The anonymous author has great style and solid insights into sensitive areas. Whoever made the decision to continue the series should be commended for having great vision. Each Inside Out has been enriching.

Paul G. Crowley, PhD
Director of Education
Tucson Osteopathic Foundation
Tucson, Arizona

(Ed note: The March and April issues have been sent to Mr Crowley.)

* * *

There are two reasons for this letter.

First, I want to tell you how much I value your outstanding publication. I read it thoroughly and share it with several of my friends. You are performing a valuable service.

I also want to express my special appreciation to the writer of Inside Out. Since I cannot do this directly, I hope you will forward my comments to him.

I study his writing as I try to improve my own modest efforts. I wish him well in his continuing work and in dealing with his addiction.

Linc Fisch
Lexington, Kentucky

Advertising bans urged

I feel more public education is needed for both alcohol and other drugs and that television and magazine advertisements for alcohol should be stopped.

I do not agree that alcoholism is a disease. No one person is ever forced to take that first drink, and no one person will quit drinking unless he or she wants to. Alcoholics Anonymous can help some.

Agencies, no matter how willing, can't stop a person, unless he or she wants to.

D. Hall
Ottawa, Ontario

Canadian statistics needed

You have had some good articles in **The Journal**. We especially appreciated the one on wine and beer in grocery stores (November, 1985).

We have not read all your articles and may have missed some things, but we do have some problems in getting facts and statistics regarding the use of alcohol and tobacco in Canada.

I am enclosing a couple of articles which give definite estimates on the cost of alcohol to the public in the United States. I don't seem to be able to get these kinds of statistics in Canada. We would like to see a comparison done on the effects of the use of alcohol compared with the effects of smoking.

Douglas H. Russell
President
Alcohol Drug Education
Red Deer, Alberta

[Ed note: **The Journal** *has published several Stats•facts covering facts and figures on alcohol, other drug, and tobacco use by Canadians: general (November, 1985), youth (June, 1985), older Canadians (May, 1986), women and men (November, 1986). We'll send them to you.]*

TJ: content and contacts

Our national coaching magazine *Coaching Review*, published its last issue in March/April.

Financial reasons were behind its demise after 10 years of providing information to coaches and other individuals involved with the coaching community.

We continue to provide information for coaches, parents, and sports administrators through various other publications; please keep us on your mailing list.

The content of **The Journal** is excellent and keeps us aware of happenings in this environment and of areas of concern to athletes, coaches, and others in the coaching community.

Steve Newman
Technical editor
Coaching Association of Canada
Ottawa, Ontario

The Journal keeps me in contact with others with like interests although I have retired as an alcoholism counsellor.

It also gives me up-to-date news which I pass on to the local school; teachers use the information for discussions in their health classes.

Irvin Goucher
Annapolis Royal, Nova Scotia

I have read a friend's copy of **The Journal** many times and have found the stories interesting and informative.

I am very interested in the field of chemical dependency and would appreciate it if you would include my name on your mailing list for a subscription.

Thank you; I look forward to reading the informative articles

Michelle Desjardins
Ottawa, Ontario

I have received **The Journal** *gratis* for several years. Each issue contains a wealth of relevant and timely information about current addiction problems.

I find it a great help in keeping abreast of developments in this area.

P.J. Maloney
Scarborough, Ontario

Correction

The Journal regrets the error in the July issue incorrectly identifying two provincial cabinet ministers. Of course, Peter Dueck is Minister of Health, British Columbia, and James Dinning is Minister of Community and Occupational Health, Alberta.

The Journal

A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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Blacks — drugs, AIDS, and survival

Blacks in the United States have always faced uphill struggles: now AIDS is added to the alcohol, drug, and violence problems in many urban areas.

The US Department of Health and Human Services, in cooperation with a network of major black organizations, delved into some of the problems — and the future — at the National Conference on Preventing Alcohol and Drug Abuse in Black Communities. Washington contributing editor **Harvey McConnell** *reports.*

WASHINGTON — There is really no difference between the prevalence of drug abuse in the white and the black populations, said Charles Schuster, director, National Institute on Drug Abuse (NIDA), referring to findings in their surveys.

However, "it (the prevalence) is higher in the urban areas than suburban areas to the extent that a greater number of blacks proportionately live in urban areas where there is a greater risk of drug abuse."

And there is a special concern now about crack in the urban areas. "It is inexpensive enough for any kid who can afford to buy a record album, about $10. They are being exposed in their most formative years to a potent and mind-altering, addictive substance."

New York Democratic Congressman Charles Rangel, chairman, House of Representatives select committee on narcotic abuse and control, is a champion of supply reduction. He said: "We are not going to win this war just staying on the sidelines thinking somebody is going to fight it for us."

In his district in Harlem, "it is a question of survival." He attacked some of the current prevention campaigns: "We have to understand that people can be blinded to such an extent that the educational process is to slap a book or pamphlet on the kid to 'Just say no,' and nobody has ever checked out whether the kid can read.

"If you take a kid who hasn't got a job, who has no job training, who is living with roaches in a dilapidated house where he cannot see any economic development or improvement, and who has no hope of ever getting out, you tell me what he has got to say 'no' to?

"What is the sense in being drug-free if indeed society is still holding him hostage, without any hope of getting out of where he finds himself?"

Mr Rangel said life for blacks has been a little better for each succeeding generation. "But, it frightens me we can't say we left the world a little bit better for those that are going to follow."

The toll of violence in the black community was spelled out by Nollie Wood, MD, division of injury epidemiology and control, Centers for Disease Control, Atlanta: homicide is the leading cause of deaths among blacks in the 15-to-34-year-old age group; and for all black males, it is the second most common cause of premature death.

Fifty per cent of victims have been involved in alcohol use. Studies in Los Angeles show a large number of blacks involved in homicides had alcohol in their blood: many were intoxicated. Dr Wood said there must be extended help for the black family, involving a network of groups to help parents and young people learn to resolve conflicts without violence.

Wali Shabazz, a crime specialist with the Tampa Urban League, has worked for the past three years in high crime areas in the Florida city. He said the Afro-American is religious and hard working. "About only 10% of the people in our community commit nearly 100% of the crimes."

One pitfall historically was the 1960s, when so many "lashed out and rejected the value system of our parents." People started using drugs, and as a result, many of today's young people "will do anything so 'I can feel good right now.' "

In an effort to provide positive black male images, the Urban League is involved with players from the Tampa Bay Buccaneers who spend time with young people every week. The football players impress on them the need for and value of education.

Brenda Otis, a producer for Black Entertainment Television, said drugs and alcohol must be deglamorized. There must be a shift in emphasis in popular TV programs to make it clear "those cars the drug dealers drive are bought with blood money."

Ms Otis: "Let's not worry about being offensive. In times of war, sensitivities are often sacrificed."

Alcohol advertising in the black community is a minefield, as shown by the differing points of view of George Hacker, director of alcohol policies, Center for Science in the Public Interest, Washington, and Wilbert Tatum, chairman, New York *Amsterdam News*, published since 1909.

Mr Hacker cited a recent report by his group which described "the zeal by advertisers" to get into the black market, even though it is a market where there is more poverty and less access to health care.

"Urban black neighborhoods are peppered by billboards promoting alcoholic beverages. They loom over homes, schools, churches, and playgrounds.

"Black-oriented magazines and radio stations carry a high proportion of ads for alcoholic beverages."

Mr Hacker said this investment by the beverage industry means many broadcasters and publishers are held hostage and are unable to take part in prevention and education efforts. At the same time, the beverage industry "sponsors a staggeringly wide array of cultural, entertainment, sports, and special events."

Mr Tatum said he resented some of Mr Hacker's presentation "because it is a real world we live in." Today, "white media and white public interest groups have suddenly discovered the black media."

He said in his newspaper less than 2% of revenue comes from cigarette and alcohol advertising. He estimates no more than 10% to 12% of revenue for black radio stations comes from the same source.

Mr Tatum said he does not drink or smoke, "but I will fight to the death for the right of any newspaper to take any advertisement that it wishes until such time as the government of the United States decides it is absolutely intolerable for us to do it.

"I am not going to go down the tube because I accept a legitimate piece of advertising that every other newspaper in the country does.

"A much more important question is narcotics: a $200-billion-a-year business, which is the same as the gross national product of blacks in the United States." But, blacks are not at the top in trafficking, and drug money is laundered by banks and investment houses which have few black executives.

Wayne Greaves, chief, division of infectious diseases, Howard University Hospital, Washington, and an expert on AIDS, said there is a disproportionate number of cases among blacks. When he pointed this out in the fall of 1985 at a press conference, "I was literally ridiculed, and I got angry phone calls from blacks and whites, but predominantly blacks, protesting.

"Things have come right around. Now everybody is on the bandwagon . . . but I will tell you the response is still far from where we would like to see it."

And while about 25% of all cases of AIDS are among blacks, that is not the case in every community. In Washington, for example, there is no disproportionate number of cases, although there is in neighboring Baltimore.

Dr Greaves said that in Washington about 91% of the black AIDS cases are in homosexuals. But the patients they now see at his hospital are HIV-positive, and most are IV drug users.

> ***'If nothing changes, we can expect an absence of black population growth'***

Although the number of AIDS cases in women and children is much lower than in men, about 50% are in black women and about 58% in black children.

Dr Greaves said he has been criticized for saying it, "but if nothing changes, and this trend continues, we can expect an absence of population growth in the black community."

He called for more blacks in the health care system and for leaders in the black community to get more involved.

Rudolph Jackson, MD, professor, department of pediatrics, Morehouse School of Medicine, Atlanta, summarizing statistics on AIDS cases, said: "IV drug abuse is at the top of the list as the cause of transmitting the virus; this is followed, obviously, by sexual contact. Blacks constitute more than 50% of females coming down with AIDS; as a result, when we look at the pediatric numbers, we are responsible for 60% of those pediatric cases that have been reported."

Dr Jackson urged caution with statistics "but be mindful of the fact we do have a problem in the minority community and, when it comes to IV drug abuse and the black community, we have a major problem."

TARGET GROUPS

Amateur sports coming to grips with drug use

Some groups still beyond control steps

By Paul Szabo

LAS VEGAS — The Sports Medicine Council of Canada has done a good job of controlling the use of performance-enhancing drugs in organized amateur sports.

But, there's concern about such drug use in sports that fall outside the control of the national amateur sporting associations.

Norm Gledhill, PhD, head of the Canadian committee on doping in amateur sports, told **The Journal**, there is currently "an awful lot of talk," about people at health clubs and weight-lifting facilities using anabolic steroids.

He describes this as "narcissistic" drug use because it involves people who want to get "bigger, faster," not competitive athletes.

Dr Gledhill and Andrew Pipe, MD, an Ottawa physician closely involved with amateur sports, were here for the annual meeting of the American College of Sports Medicine. They agree the Canadian Council has "been successful in stopping the use of certain drugs at certain times."

Dr Pipe: "Our biggest problem with drug abuse in Canada in sports right now, outside the professionals, is with athletes who are involved in things like body building or power lifting." (**The Journal**, July).

Golobitsh

High school and college athletes: steroid use a "much bigger" problem

He said this is because these athletes operate in isolation and there is no overall organizing body.

Dr Pipe is also critical of professional sports organizations which continue to allow the use of performance-enhancing drugs.

"Professional sport almost uses its interest in recreational alcohol and drug abuse as a marketing tool," he said, "while at the same time, they pay absolutely no attention to the components of drug abuse which are very real problems in professional sport."

He said there is "absolutely no" program for controlling use of anabolic steroids in professional sports, and there is good reason to believe their use is a real problem.

"If you're going to deal intelligently with drug abuse in sport, you have to deal with all the drugs.

"I think it's hypocritical to portray a league as being tremendously concerned about the welfare of the community in so far as drug abuse is concerned when they only want to talk about recreational drug abuse. They're quite happy to ignore the realities of steroid abuse that might be right in their midst."

In amateur sport, Dr Gledhill said, steroid abuse is "a much bigger problem" at the college and high-school level, especially in sports such as football.

While the doping committee has no mandate to control directly the use of performance-enhancing drugs outside of the national amateur arena, Dr Gledhill believes education programs are reaching athletes at all levels.

Arbitration ruling makes possible test appeals

LAS VEGAS — Canada will probably have to go to an expensive system of "sampling marshals" to collect urine samples for drug testing of athletes involved in amateur sporting events, in the wake of a successful appeal by a weight-lifter suspended for using an illegal performance-enhancing drug.

That's the opinion of Norm Gledhill, PhD, head of the Canadian committee on doping in amateur sport.

Dr Gledhill commented on an arbitration-hearing decision in which the suspension of an athlete was struck down: the judge ruled the sample which tested positive could conceivably have been tampered with during the testing process.

The collection of samples for drug testing during amateur events in Canada is currently under the direction of the federation sponsoring the event.

Following the arbitration decision, Dr Gledhill told **The Journal** the decision shows the arbitration process established in Canada does work.

But, "now everybody, I assume, is going to appeal."

The government will probably develop a system similar to the United States with trained sampling marshals flown to each event.

Alcohol, women who drink, and their children

By Joan Hollobon

TORONTO — Fetal Alcohol Syndrome (FAS) is one of the top three causes of mental retardation and its leading preventable cause in Canadian society.

Joyce Schneiderman, MD, told a forum here on Women's Perspectives on Alcohol, women who are chronic, heavy drinkers have a 40% chance their babies will have facial abnormalities and be stunted in their physical and mental development.

It is important to recognize drinking among women of childbearing age because evidence also exists that even moderate drinking can lead to more subtle adverse effects, said Dr Schneiderman, a staff physician, Ontario's Addiction Research Foundation here.

There is no evidence, however, that one episode of intoxication or an occasional drink is harmful, although the "safe" lower threshold is unknown (**The Journal**, June), she said.

The forum was sponsored by Women's College Hospital (WCH). Ann Medina, Canadian Broadcasting Corporation (CBC) television producer-journalist, was moderator, with panelists Gwen MacLachlan, a PhD student and instructor, York University; Margaret Muir, a former counsellor with the Jean Tweed Treatment Centre here; and, Dorothy Kirby, Ontario Advisory Council on Women's Issues, who described herself as a recovering alcoholic.

Anne Rochon Ford, WCH policy advisor on women's issues, said women and alcohol was chosen for the lecture series' topic because of the hospital's current drive to establish a women's detoxification centre.

'There are ways in which the issue of women and alcohol needs to be looked at separately from men'

"We are trying to raise awareness among our staff and in the community that there are ways in which the issue of women and alcohol needs to be looked at separately from men."

Metro Toronto has no detoxification centre for women; there are only about eight beds for women in detox centres, compared with about 100 for men, Ms Ford said.

Outlining differences between men and women in the patterns and effects of drinking, Dr Schneiderman said women's alcohol-related problems have been changing since the Second World War.

Heavy drinkers are found now most often among teenagers and women in their 20s and 30s. Women are more likely than men to have had drinking parents, and alcoholic women are more likely to be divorced or separated, or living with a man with an alcohol problem. Women's drinking is more often escapist, related to psychological stress; women are more likely to suffer from low self-esteem, and women with alcohol problems are also more likely to abuse tranquillizers.

And, Dr Schneiderman said, women's drinking history is likely to be 'telescoped' — despite their beginning to drink at a later age than men, their greater susceptibility to the adverse effects of alcohol makes them vulnerable to severe illness, such as liver cirrhosis, at a younger age and after fewer years of drinking (**The Journal**, May, 1986).

Dr Schneiderman said denial among women, their families, friends, and employers is greater. Women are also more likely to be treated for emotional problems than to face a direct approach to their drinking.

Gwen MacLachlan told the forum male heavy-drinkers associate drinking with all their activities — a beer in the left hand and a fishing rod in the right; women reduce their activities until everything revolves around the acquiring and drinking of alcohol.

Women who recognize their problems are more likely to seek help, she said. But, many people around women are enablers, unwittingly contributing to the women's continued drinking. For example, one woman was stopped for drunk driving three times in one evening. The first two police officers simply told her to go home; the third, arrested her.

Dorothy Kirby explained she was one of 13 children in a family in Newfoundland; her parents did not drink excessively. However, as a child, she felt she never "fitted in," and she lacked the discipline to become a good student. After leaving school at 16 years, she began drinking. "Nothing serious, but a lot of my dreams changed," including becoming a nurse.

"In the beginning, I drank because I wanted to. In the end, I drank because I didn't have a choice."

Margaret Muir told the forum that having alcoholic parents — in addition to being "traumatic and painful" — makes children of alcoholics (COAs) four times as likely to become alcoholic themselves. They may inherit a genetic susceptibility, and they grow up learning alcohol can solve life's problems.

COAs may be physically abused or sexually abused, and many display traits such as stuttering or bed wetting. Some become shy and withdrawn; others become overly responsible, caring for their parents. Many find it too painful to risk showing their feelings; they fail to develop trust. They learn not to talk about what goes on at home.

Daughters form group

TORONTO — The Women's Perspectives forum here was told of a new organization, the Ontario Association of Adult Daughters of Alcoholics, based in Toronto.

Betsy Dalton, one of the three founders told The Journal the Ontario association is an independent body, although some of its members also belong as individuals to the Canadian Association of Children of Alcoholics (The Journal, January).

The Ontario association will hold three events this month (September) related to its aims of awareness, intervention, and prevention: a public information evening in Toronto, a one-day training seminar for professionals, and a two-day retreat.

VOL. 1 NO. 2 SEPTEMBER 1987

INSIGHT

by Joan Marshman, PhD

'Government support for community-based treatment services is paying off — fiscally and societally'

ADDICTION RESEARCH FOUNDATION'S ONTARIO REPORT

Drug/Addiction Awareness Week

- what's happening
- who to call
- how to approach the press

ARF surveys drug use by adults in Ontario

TORONTO — An extensive survey just completed by the Addiction Research Foundation (ARF) suggests little change in adult use of alcohol and other drugs over the last 10 years.

In fact, cannabis use among 18-to-29-year-old males — traditionally the group using the drug the most — appears to be declining.

Alcohol use appears to be relatively stable, with 18% of the respondents reporting drinking two to five times per week, compared to 16% who said they did 10 years ago.

And, even though newspapers are trumpeting "it's everywhere," only 6.1% of people in Ontario report ever having tried cocaine.

Other highlights of the survey by Reg Smart, PhD, and Ed Adlaf, include:

- Cocaine use seems to be mainly limited to Metropolitan Toronto. Income appears to be no barrier: use is highest among those with incomes of $10,000 or less. Use of crack is still rare, even among those who report having tried cocaine.
- Cannabis is used mostly by those aged 18 to 29 years and those in sales, clerical, or labor jobs.
- Binge drinking — more than five drinks in a sitting — is highest, and on the increase, among men 18 to 29 years old. Since 1984, binge drinking among women aged 18 to 29 years has increased.
- Although women older than 50 years are the biggest users of sleeping pills, young women have increased use (to 7.2% from 2.2%). Use is highest among Ontarians outside of the workforce, with elementary-level education, and a family income less than $10,000 a year.
- Only a small percentage of respondents said they use stimulants, pep pills, or diet pills; of those, people aged 18 to 29 years report the highest rate of use.
- Tranquillizers are the most commonly used of the drugs surveyed. The disabled and retirees (14%) report the most usage, followed by housewives (12%), the unemployed (6%), and students (5%).

For more on the ARF survey, see page 4.

The Drug/Addiction Awareness Week team: addiction workers province-wide gear up for November

ARF aims for awareness

OSHAWA — All divisions of the Addiction Research Foundation (ARF) are in high gear for Drug/Addiction Awareness Week, which takes place this year from November 15 to 21.

The cross-Ontario, and cross-Canada event highlights activities of all groups dealing with problems related to alcohol, other drugs, and tobacco, to make communities aware of the issues and get them involved in increasing this awareness.

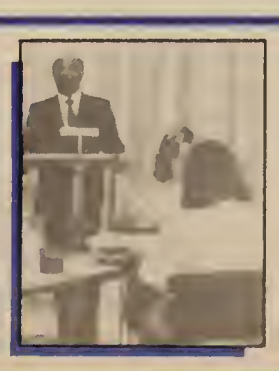
ARF staffer Suzin Jackson of Durham region is the provincial coordinator: she's optimistic this year's Drug/Addiction Awareness Week will be the most active since the event's inception in the early 1980s.

"We've got involvement from all of the different ARF divisions, the Royal Canadian Mounted Police drug squad, the Countermeasures program of the Attorney-General's office, the Solicitor-General, the Alcohol Recovery Homes Association, and the National Native Advisory Council."

Many of the groups participating in Drug/Addiction Awareness Week are chaired by ARF staff, so the Foundation's leadership role is increasing. Ms Jackson emphasizes, however, that each group plans its own events, aiming at particular problems in the home communities.

For more on Drug/Addiction Awareness Week, see pages 2/3.

IN THIS ISSUE



INSIGHT

The Dollars and Sense of Community-Based Treatment Services

Cost-effectiveness and accessibility are two of the buzzwords in the effort to manage Ontario's health care delivery system. Government, providers, and consumers alike recognize that successful management of the health-care dollar depends on finding better approaches to old problems.

Both concepts have been integral to the recent development of addictions services in Ontario. In the last few years, the Ministry of Health's increased funding in this area has facilitated the introduction of new types of services — assessment/referral/case management and day treatment — as well as the expansion of detoxication and outpatient services across the province.

The cost-effectiveness idea challenges us to put our health-care dollars where they will be most effective. Importantly, research indicates inpatient hospital services are no more effective in treating most alcoholic patients than less-expensive outpatient services. Therefore Ontario's increased development of community-based services does represent a more cost-effective approach to alcoholism treatment.

Early on, it was recognized hospitals would continue to play an essential role in treatment, especially in handling some of the physical and psychiatric complications of alcohol abuse. However, they would cease to function as the cornerstone of Ontario's alcoholism treatment system. The net result of this shift would be to free hospital beds formerly occupied by patients being treated for alcoholism, for other patients for whom the beds were absolutely essential.

Sceptics argued that an expanded community services system would simply be an "add on" (ie, unnecessary) expense, with hospitals continuing to play their traditional role in alcoholism treatment — and continuing to rack up their traditional costs in the process.

Not so, to this point at least. A recent study by ARF scientists indicates a significant decrease in hospital utilization rates for alcohol-related diagnoses. The rates fell particularly in areas with new detoxication centres and/or assessment/referral/case management centres. It is encouraging to see this reduction in use of Ontario's hospital resources: the hope is the trend will continue over the longer term to generate further hospital care savings.

The story doesn't end there, however. Another important benefit of the government's increased funding for community-based services is increased accessibility of treatment services. The intent, and result, of this initiative is to make specialized treatment services accessible to a larger proportion of Ontarians with alcohol and other drug problems in the form of a continuum of care — from detoxication and assessment through specialized intensive treatment and follow-up. While there is still work to be done, the fact is the momentum and commitment are there, and the system has improved and expanded even as hospital utilization has declined.

The government's support for community-based treatment services is, then, paying off, both fiscally and societally.

Joan A. Marshman
Joan A. Marshman
President, ARF

ADDICTION RESEARCH FOUNDATION'S
ONTARIO REPORT

Published by the Addiction Research Foundation
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Awareness week foc

TORONTO — Drug/Addiction Awareness Week in Ontario, November 15 to 21, will see even more involvement by community groups and professional associations this year, and the Addiction Research Foundation (ARF) will play a leading role.

Traditionally, the event has been called Addiction Awareness Week, and many local groups will be retaining that title. Some have adopted a new name, Drug Awareness Week.

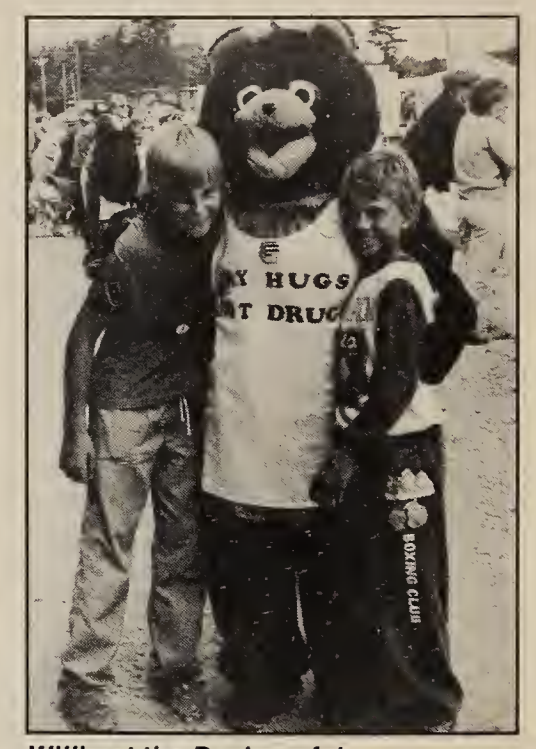
Since the early 1980s when the first event was organized by a few interested groups, the focus has been on heightening public awareness of the dangers of addictions and providing information on treatment services.

This year, Drug/Addiction Awareness Week should get a real boost by being tied in to the federal government's national drug strategy (**Ontario Report,** June), says the Foundation's Henry Schankula, director, Education Resources.

"We're really reaching the community movers and shakers this year. And, we've got industry groups like Burger King, General Motors, and the Canadian Auto Workers all pitching in."

Mr Schankula says he's never seen such a climate for prevention and reduction of demand for drugs in all his 25 years in the field.

Because many participating groups



Willie at the Durham fair

are chaired by ARF staff, the f
tion's leadership is evident. Pro
coordinator Suzin Jackson of
Durham region emphasizes th
local group plans its own event
to problems in the local comm

Peel region has a full Drug A
Awareness Week agenda w
mock trials planned for sec
schools. ARF staffer Anna
who's coordinating the week
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judges are donating their time
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students playing the parts of th
ed and other witnesses.

An ongoing series of worksh
also be launched in Peel dur
/Addiction Awareness Week
trying to reach that group o
whose kids are just dabbling
and not in trouble yet. The pa
worried sick and don't know
go," Ms Miller said.

Professional development
guidance counsellors — on d
alcoholics — are also a part o
program.

Mary Pakula, an ARF staf
West Metro Toronto region
ipating the participation of
Toronto Pharmacists' Assoc
year: "We're trying to reach
al public more, so the pharm
be distributing information
on drug awareness."

For the first time, the Toro
Commission (TTC) is getting
act. The electronic subway s
display date, time, and m
also be running messages ab
Addiction Awareness Week

And because West Ma
wants to find out what works
hospitals more involved, a p
is being run for both staff a
in six Metro hospitals.

RACE: for media coverage

Do you want publicity for your local Drug/Addiction Awareness Week activities?

Media Relations, Addiction Research Foundation, Toronto, advises local groups to ensure that all promotional items support the main theme or slogan for the week; that spokespeople be coached to stick to three key items; and, that promotion be organized to a "RACE" formula:

R - research: know your local media, their deadlines, editorial policies, and information needs.

A - analyze/action: decide which information, spokesperson, and medium best suit your message;

C - communicate: get credible, quotable spokespeople, ensure their accessibility, distribute press kits six weeks before the events, media kits one month before, and follow-up by phone the day before.

E - evaluate: keep clippings, pictures, and records of television and radio spots to see what worked, what didn't, in planning for next year.

National strategy budget plan

Provincial committee to review proposals

TORONTO — Ontario groups looking for funds from Canada's national drug strategy budget can soon turn to a provincial review and assessment group for help.

"Funding for the rest of this fiscal year (until March, 1988) will be announced by Health Minister Jake Epp this month, and then the decision-making process can begin," reports Henry Schankula, director, Education Resources, Addiction Research Foundation, and chairperson of the national working group on community action programs.

Mr Schankula expects funds to be limited this year but to increase over the next few years.

"The grants will be development funds for local community groups, not for ongoing programs," he explains.

"There may be other mechanisms within the national strategy — the 50/50 federal/provincial cost-sharing program, for example — for ongoing programs. Under the community action programs, the grants will be for community-level projects."

The new Ontario review and assessment group will ensure provincial as well as national priorities are met.

"These are very similar. The focus will be on young people and collateral family members — not that other target groups will be ignored. Youth is the prime target group; others will include women, cultural groups, and socially isolated groups."

The community action program under the national drug strategy implementation program represents "an exciting collaboration between the provinces and the federal government," says Mr Schankula.

"It's very clear that the federal government wants the provinces to make the decisions at the community level so that the implementation of the national strategy represents priorities at that level."

He points out: "There'll never be enough money from government sources to do everything we want to do in the addictions field. That's why identification of what's important at the community level is so important."

While groups may consider complete government funding as ideal, Mr Schankula says, from his experience in grants programs over the years, he knows it can turn out to be a negative.

"When you get lots of g
money flowing into a proje
be a loss of initiative and
Much of the excitement a
around local projects is ge
the need to obtain funding

ACTION
ON DRUG ABUSE
CONTRE LES DROGUES

THE FACT FI

**In any one particular yea
erage adult Ontarian has**

- **one in 11 chance of sleeping pills**
- **one in 11 chance of marijuana**
- **one in 15 chance of tranquillizers**
- **one in 38 chance of stimulants**
- **one in 360 chance of charged under Canada laws**
- **one in 640 chance of treated in hospital for related illness, includin lems associated with le illegal psychoactive dru**
- **one in 42,000 chance of a diagnosed drug-rel ness**
- **one in 6,500,000 chanc ing from being struck b ning anywhere in Canad**

ocuses attention on addictions

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a pilot project
and patients

Ontario colleges and universities are mounting their own events, with help from the ARF. Challenges — to a week of no smoking, no drinking — will be a feature of campus efforts.


Schankula

Ms Jackson reports shopping mall displays are very popular, especially when the week's mascot, Willie the Bear, attends.

Willie promotes the slogan, 'Try hugs, not drugs,' to emphasize the need for caring support to help people with drug problems and for reaching out to others rather than to drugs.

The hard-to-reach groups tend to be the most influential with the public, says Ms Jackson. Physicians and lawyers have been especially targeted through their associations, which are including items about Drug/Addiction Awareness Week in their newsletters.

The physician member of ARF's Durham region Board, Dr Allan Fegelman, has prepared a physicians' handbook on addictions and is organizing a dinner event with a guest speaker for the medical profession. Clergy have also been targeted, since discussion groups in churches have attracted more than 100 people to each event.

The Ontario Attorney-General's office is backing up the provincial Drug /Addiction Awareness Week with literature from its Countermeasures program against drinking and driving.

John Bell told **Ontario Report** requests for, 'No thanks, I'm driving' buttons are coming in thick and fast, as are orders for pamphlets on the consequences of drinking and driving, window decals, and posters.

Ontario's Ministry of the Solicitor-General is mounting a 'Drugs and sports don't mix' program in which local police departments train team managers, trainers, and coaches to recognize drug problems and prevent them if possible. Literature is supplied by the ARF.

Herman Myers explains that trainers are now required to take this program before getting Level 2 certificates. Hockey is the first sport to be targeted, with the backing of the National Hockey League (NHL).

"The demand has been great," notes Mr Myers. "We've had requests for 500 kits from North Bay alone."

Joe Taylor, director, St Vincent de Paul Homes for recovering alcohol and other drug users, has been involved with Drug/Addiction Awareness Week since its inception. He says the event has brought awareness of drug-related problems — and solutions — to the grassroots level.

What's available:

Interested in putting on displays or other activities in your area during Drug/Addiction Awareness Week, November 15 to 21?

The following organizations can help with support materials:

- **Addiction Research Foundation, Marketing Dept, 33 Russell St, Toronto M5S 2S1.**
- **Ministry of the Attorney-General, Countermeasures Office, 8th Floor, 10 King Street East, Toronto M5C 1C3.**
- **Ministry of the Solicitor-General, Policy Development and Coordination Branch, 11th Floor, 25 Grosvenor St, Toronto M7A 1Y6.**
- **Local Alcoholics Anonymous, Alateen groups.**

ARF Contacts:

There are Addiction Research Foundation contact people whom you can call for more information on Drug/Addiction Awareness Week.

If you want to get involved, but aren't sure how, give any of these ARF contacts a call:

Halton	**Steven Moore**	**416-632-2436**
Peel	**Amina Miller**	**416-270-1431**
Durham	**Suzin Jackson**	**416-576-6277**
West Metro	**Mary Pakula**	**416-595-6090**
Barrie	**James Simon**	**705-726-4976**
Sudbury	**Reggie Caverson**	**705-675-1195**
Sault Ste Marie	**Ann Pollard**	**705-256-2226**
Timmins	**Betty Findlay**	**705-267-6419**
Thunder Bay	**Ken Moffatt**	**807-622-0607**
Kenora	**Len Bryon**	**807-468-6372**
Hamilton	**Marg Green**	**416-525-1250**
Kitchener	**Paula Stanghetta**	**519-579-1310**
Simcoe	**Toby Barrett**	**519-426-7260**
Niagara	**Karen Ferruccio**	**416-685-1361**
	Carmella Di Flumeri	
London	**Maeve Connell**	**519-433-3171**
Owen Sound	**Dave Docherty**	**519-371-1861**
Chatham	**John Zarebski**	**519-354-1000**
Sarnia	**Angie Chiu**	**519-354-1000**
Windsor	**Einar Lund**	**519-253-1146**
Ottawa	**Sylvia Lefort**	**613-722-1075**
Belleville	**Linton Heth**	**613-962-9482**
Cornwall	**Peter Barkway**	**613-932-3300**
Peterborough	**Brian Mitchell**	**705-748-9830**
Kingston	**Lyn Lightfoot**	**613-546-4266**
Pembroke	**Joanne O'Connor**	**613-735-1023**
Community Programs Evaluation Centre	**Louis Gliksman**	**519-661-3042**
Employee Assistance Programs	**Judy Keaney**	**416-595-6028**
Regional Office, Metro Toronto	**Wilfred Orgias**	
	Andrea Lavigne	**416-595-6020**

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Extension programs serve communities

Taking education where it's needed

TORONTO — How do you find opportunities to expand your knowledge of the addictions field if you live in Cochrane?

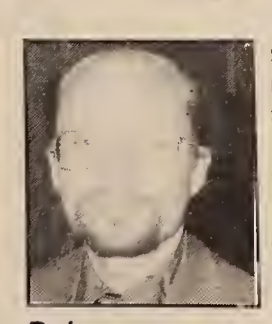
When Mohammed can't come to the mountain, the mountain must come to Mohammed.

That's the philosophy that took two faculty members from the School for Addiction Studies (SAS), a division of the Addiction Research Foundation (ARF), to Cochrane last year — and that inspired 72 other Extension programs across the province.

Peter Bohm, PhD, director, SAS Extension programs, says Distance Education programming not only takes education where it's needed, but also tailors it to the community's specific needs.

"That may result in a drinking and driving countermeasures program for students, teachers, and principals in Thunder Bay; or, a one-day symposium on children of alcoholics for agency professionals in Sault St. Marie."

At the beginning of the year, each ARF regional office plans 16 days of extension programming. The needs are determined locally, through consultation between the local ARF person and a community representative.


Bohm

Dr Bohm says the atmosphere in a group with a common frame of reference is very different from that in a disparate group from many regions. "The local input is crucial; we have very close connections."

Last year, the School put on 72 Extension programs, for a total of 3,000 participants, over 222 days of courses.

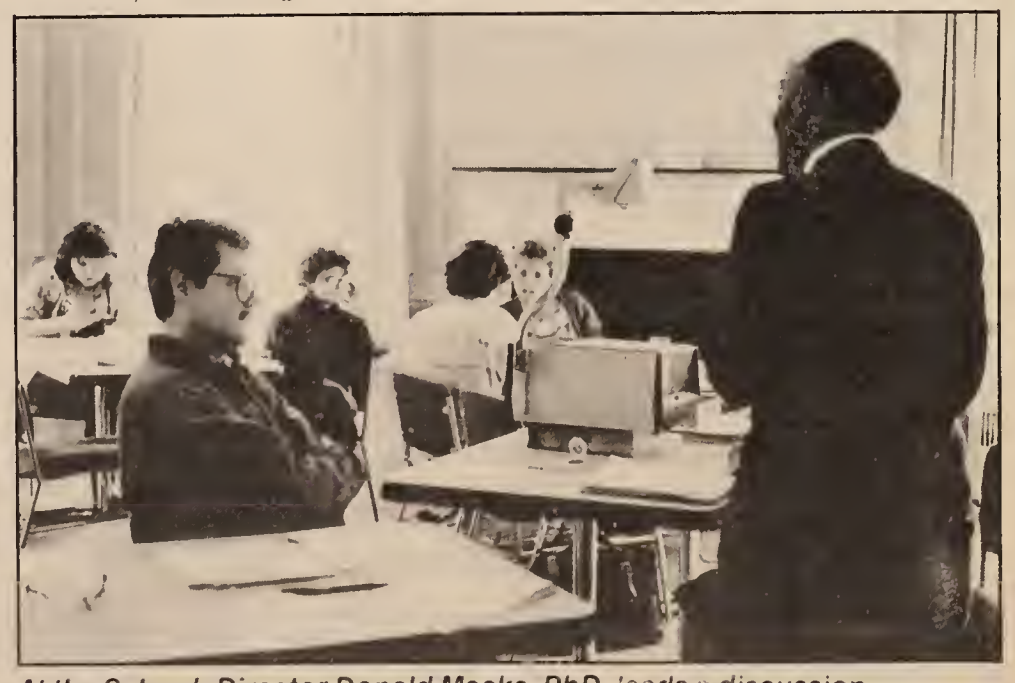
The programs range from multimedia packages — with video- and audiotapes, print materials, visiting lecturers, and tutoring by telephone — to short courses with visiting faculty, to teleconferencing, Distance Education, which can include all 30 centres simultaneously if necessary.

As well as accessibility, cost is a factor in the success of Distance Education, says Dr Bohm. "We can put on a teleconference for 35 people for under $800, and no one will have more than an hour's travelling time."

Extension programs reflect SAS's original purpose when it opened in the late 70s. Then, most of the education was aimed at the ARF's own staff, with future outreach planned.

By 1983, 35% of the participants in courses were non-ARF. Today, that figure's up to 90%. "It's a way of more fully mobilizing what the ARF has to offer," says Dr Bohm.

For more information on Extension/ Distance Education programs, contact the School, 8 May Street, Toronto M4W 2Y1, (416) 964-9311; or call your local ARF regional office. SAS calendars are also available from the School.


At the School: Director Donald Meeks, PhD, leads a discussion

Adult alcohol, other drug use in Ontario over 10 years

TORONTO — Addiction Research Foundation (ARF) researchers have completed a survey which indicates alcohol and other drug use by adults in Ontario has remained stable over the last decade.

There even seems to be a decrease in cannabis use among young men, generally the most frequent users.

Those are the findings of a 10-year survey just completed by ARF researchers Reg Smart, PhD, and Ed Adlaf. The survey results challenge recent newspaper stories about alcohol and other drug use among different groups and will help workers target assistance more accurately, says Dr Smart, head of ARF's prevention studies.

The survey was started in 1977 and repeated in 1982, 84, and 87. It examines frequency of use for alcohol, sleeping pills, stimulants, tranquillizers, cannabis, and cocaine among Ontario adults.

Using the Gallup Ontario Omnibus, the researchers sampled population areas from large cities to rural villages to get a representative group of all adults more than 18 years old.

Data were analyzed according to age, sex, geographic location, education, occupation, and gross family income.

'The survey will help workers target assistance more accurately,' says Reg Smart

Cocaine

The survey is the first to estimate cocaine use in the form of crack among Ontario adults: it suggests use is rare in Ontario — 0.7%, compared to 4% among United States high school seniors.

Dr Smart comments that although more adults in Ontario are reporting having tried cocaine once (6.1%), which should be viewed with concern, "the perception that crack use in Canada is either epidemic or at levels comparable to the US is unwarranted at this time."

The number of people reporting cocaine use "in the last 12 months" remains unchanged between 1984 and 1987, although the number reporting ever having used cocaine seems to have increased, especially among 18 to 29 year olds, where it has doubled.

Cannabis

Cannabis use appears to be declining among the 18 to 29 year age group and increasing among 30 to 49 year olds.

Dr Smart considers this latter group is a "heavy-user cohort" — those who got used to smoking marijuana in the 1960s still smoke, while youngsters are not necessarily taking it up.

Alcohol

In drinking patterns, older men report the highest rate of daily drinking. Overall, however, rates of daily drinking remained constant throughout the 10 years. The pattern seems to show increases in binge drinking (more than five drinks in a sitting) among younger adults, especially men in northern Ontario, and among those with post-secondary education.

Binge drinking among young women increased from 1984 to 1987, but the 87 rate doesn't differ from the 82 rate.

Stimulants

Stimulants used to be a kids' 'kick,' and while use is still more likely in those aged 18 to 29 years, more than half of users say they use stimulants only once a month or less.

Sleeping pills

Sleeping pill use doesn't appear to be on the increase, except among young women: up to 7.1% in 1987 from 2.2% in 1984.

Nevertheless, Dr Smart believes the apparent increase may not be born out in subsequent surveys: "I don't think it's a long-term trend."

Tranquillizers

Tranquillizers appear to be the most frequently used drug. Daily use is also highest of the drugs surveyed: 38.7% of tranquillizer users take them daily.

People without jobs seem to take the most tranquillizers, although overall use decreased over the decade of the ARF survey.

And, housewives don't top the poll; that spot's reserved for the disabled or retired. Those with elementary school education are three times as likely to take tranquillizers as those with post-secondary education, as are those with an annual family income less than $10,000 compared to those whose annual family income is $50,000.

General

Dr Smart acknowledges that under-reporting — estimating use as less than it is really — is "very likely" and a "major problem" in most surveys.

"Cannabis users tend to be fairly accurate in their reporting," he says.

But, he acknowledges that cocaine users may differ: "No one's yet done any validity studies on cocaine use, and it really ought to be looked into."

Commenting on the use of cocaine by those with a family income of less than $10,000 a year, he points out many of those would be unemployed or students: their incomes may be low at the time of the survey, but may have been much higher, or may leap in the future.

Dr Smart sees no cause for alarm in any of the figures and views the decrease in cannabis use among young men as encouraging.

He suggests there was probably an increase in cocaine use in 1985 which has since dropped off. "Maybe, the increase has peaked, and we've reached a plateau. We can at least tone down the panic a little; cocaine's not going away, but its use isn't increasing."

NEW from ARF

"You Can't Get Away from You"

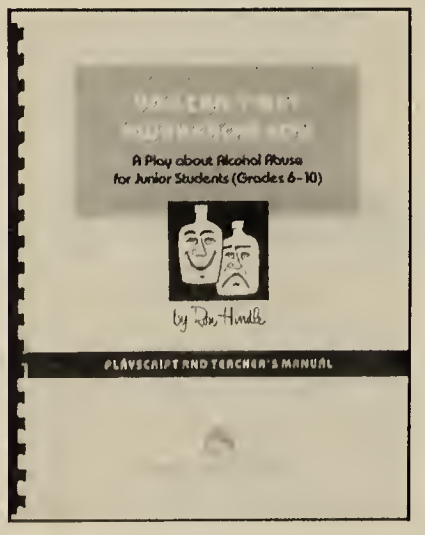
A play about alcohol use for junior students (Grades 6-10)

Written by Ron Hindle, a teacher at Markham District High School, Markham, Ontario, and produced by the Addiction Research Foundation, this script is an example of collaborative work between the Foundation and other groups.

The play, a series of 14 scenes for a cast of eight actors, illustrates many effects alcohol use and abuse can have on the school, social, and family lives of young people.

Stories are presented as discussion starters; they are not resolved. The ending is left to the audience and the actors.

With a minimum of props and sets, this play is a learning opportunity for the audience and the cast. The text suggests a variety of uses for the play and provides a short list of other resources available to students on the subject of alcohol abuse.



For more information: Marketing Services, Department OR, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1. (416) 595-6056.

Teddy bears too

Hugs, not drugs; that's the message of Drug/Addiction Awareness Week across the province. To bring that message home to parents and children, the Addiction Research Foundation (ARF) now has an "I LOVE HUGS" teddy bear.

Made especially for the ARF by DAKIN, the bear has a red appliquéd heart and a sash bearing the slogan "I Love Hugs."

Available from the bookstore, *Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1. $9.95.*

What When Where

The Law and Liability of Alcohol Providers — September 15, Sarnia Library Auditorium. This seminar co-sponsored by the ARF Sarnia/Chatham Centre and Co-operators Insurance Company is part of a campaign to market a Server Intervention Program in Lambton County. Speakers include ARF consultant Robert Solomon, a law professor at University of Western Ontario. Contact: Angelina Chiu, Lambton County, (519) 337-9611, John Zarebski, Kent County, (519) 354-1000.

Orientation to Assessment Workshop — October 5-9, Addiction Research Foundation, 33 Russell St, Toronto. A one-week workshop for new assessment and case referral workers from centres across Ontario will be conducted by the ARF Waterloo Region Alcohol and Drug Assessment Service. On-site practice training will be offered following the workshop. Contact: Darryl Uptold (519) 579-1310.

Identification & Management of People with Drinking and Drug Problems — October 20, Talisman Motor Inn, Ottawa. This one-day workshop, geared to health professionals, is sponsored by the ARF Ottawa Carleton Centre in cooperation with the Addiction Research Foundation's School for Addiction Studies and the Royal Ottawa Hospital. Registration fee $50. Student reg. $25. Contact: Virginia Carver (613) 722-1075.

National Occupational Therapy Week — October 27-31, ARF's Clinical Institute, Toronto, celebrates National Occupational Therapy week with displays, educational rounds, and an open house. Contact: Aida Cabecinha (416) 595-6133.

Management Techniques for Family Physicians — December 9, University of Western Ontario ARF London Centre and Faculty of Medicine UWO, hold a workshop on addicted patients. Contact: Don Morgan (519) 433-3171.

'No policy, no coordination, no data'

National anti-drug thrust fails to jell in Israel

By Michael Kesse

JERUSALEM — A scathing indictment of authorities for their failure to coordinate anti-drug efforts is contained in the latest annual report of Israel's state comptroller.

Each government agency comes in for biting criticism — some more, some less — for ineffectual anti-drug attempts in their areas. These include the ministries of: education and culture, labor and social welfare, health, police, prison services, and the Israel Defence Forces.

The report deals mainly with 1986, but draws extensively on material from the preceding few years. A 30-page chapter in the 960-page report is devoted to the subject of drugs; all other chapters deal with specific ministries or government bodies, not with a particular subject.

Authorities here declared a nationwide "war against drugs" during 1987. But, it seems little will actually be done — can actually be done — in the remaining few months except, perhaps, to stir more public awareness of the problem.

Recommendations to set up one overall coordinating body were made a decade ago and repeated by an inter-ministerial committee in 1983.

Statistics highlight the deterioration of the situation here: in 1986, the Ministry of Health estimated there were 15,000 drug users, compared to 3,000 to 4,000 in 1977.

But, the report stresses, these are only estimates. It criticizes the lack of data on the drug scene here.

Police, based on their workload, estimate the 1986 number of addicts at between 5,000 and 10,000 (mainly heroin users). Moreover, they suggest that in 1986 another 200,000 people were one-time or occasional drug users.

Some months ago, the police officially declared drugs were costing Israel nearly one billion dollars a year, about 4% of the gross national product (**The Journal**, April).

The problem of lack of accurate records begins in the Ministry of Education and Culture, which differentiates between two types of students: 12-to-18-year-old active users who actually push drugs (generally hashish), and passive users who are tempted once (or more often) to take a drug and remain more or less indifferent once their curiosity is satisfied.

Standard directives state that passive users should be treated within the framework of their schools if they participate willingly. They should not be stigmatized by transfer to the probationary service or the police youth department, where they will have a record once files are opened.

Active users, although their cases are transferred, remain in school. But, teachers receive no instructions on how to treat these youngsters or to aid in their rehabilitation.

The Ministry of Labor and Social Welfare is responsible for 4,000 to 5,000 people 14 to 25 years old who neither study nor work. About 25% are believed to use drugs. Little is being done to help this group: a five-man unit was authorized in 1978, but it was staffed by only one person.

The Ministry of Health has no overall policy to deal with the drug problem, despite its central role.

Specifically, there are no programs for rehabilitation of drug addicts, for gathering data, or coordinating internal units.

Schildkraut

Cigarettes in hand: soldiers walk the streets of Tel Aviv

Of the estimated 15,000 drug addicts, only 500 receive treatment in the four detoxification stations under ministry supervision. There are no data on success or failure rates in these four stations.

The Ministry of Police has also been lax.

Despite court orders to destroy drugs used as evidence after a trial ends, some drugs were warehoused up to 17 months after the court orders were received.

In 1984, police seized 5,954 kilograms of hashish and 6.5 kg of heroin. In 1985, they seized 4,543 kg of hashish — Israel's lesser involvement in the Lebanon can account for this — and 6.7 kg of heroin.

The greatest concentration of addicts here is in prisons. Of 5,500 criminal prisoners, the Prison Service estimates 3,600 to 4,900 use drugs on a regular or occasional basis. Visitors are not searched due to the liberality of prison authorities.

Smokers ignore 15 years of prevention programming

TEL AVIV — The percentage of Israelis who smoke has not fallen significantly in 15 years despite laws banning tobacco advertisements, public warnings about the dangers of smoking, and the outlawing of smoking in public places.

A joint study by the Technion (Haifa Institute of Technology) and the Histadrut (the General Federation of Labor) encompassed more than two-thirds of all Israelis and collated information from 26 surveys and investigations.

The results show about 12% of smokers started before they were 13 years old. Influencing factors include: older brothers, sisters, and parents who smoked; going out to work at an early age; not continuing studies; and, coming from a North African (Moslem) environment, rather than a European (Christian) one.

The study established another important fact: there is a definite correlation between early smoking and later (in high school) use of hashish, drinking alcohol, and having sexual relations without taking precautions. All three factors lead those involved to drop out of school at a higher rate than other students.

GILBERT

Adult children of alcoholics: I

Adult children of alcoholics may be twice blighted — by a genetic disposition to abuse alcohol or to be ill in other ways, and by their accommodations to an alcohol-abusing parent during childhood. In this column, I'll review current information on the inheritance of alcoholism. Next month, I'll write about legacies of a childhood experience of parental alcohol abuse.

Data on the inheritance of alcoholism can be summarized in this way:

• Alcoholism runs in families. The more alcoholic relatives a person has, the more likely he or she will be an alcoholic. Sons and daughters of alcoholics have a 50% to 100% higher than average risk of becoming alcoholic, other things being equal.

• The familial nature of alcoholism appears to increase with increased prevalence of alcoholism in a population.

• The familial nature of alcoholism appears to be genetic rather than environmental. Studies of adopted children have shown that they are more likely to be alcoholic if they have an alcoholic biological parent, but growing up with an alcoholic adoptive parent does not increase the likelihood of alcoholism.

• Sex is important, for three reasons:

— In studied populations, there are three to five times as many male as female alcoholics: typically 20% *vs* 5% of adult males and females respectively in North America and Europe.

— The genetic contribution to alcoholism is clearer in males than in females, at least in some studies. The lack of clarity may be because of the smaller number of female alcoholics and the consequent difficulty in making comparisons.

— Where the genetic contribution to alcoholism is clear, it appears to play a larger role in female than in male alcoholism. Typically, 30% to 40% of alcoholic females, but only 20% to 30% of alcoholic males, report an alcoholic parent.

'Children of alcoholics begin life with some built-in disadvantages'

• The consequences of alcoholism appear to be more severe in alcoholics who have a familial history of alcoholism. In one study, for example, 60% of familial alcoholics were found to have suffered major head injury at one time in their lives, compared with 35% of non-familial alcoholics.

The reasonable conclusions from these data are:

• Inasmuch as the two can be compared, environmental influences seem stronger than genetic factors in the determination of alcoholism (but growing up with an alcoholic does not provide an environment conducive to the development of alcoholism).

• Heredity and environment interact to determine both the incidence and the severity of alcoholism. Factors in the environment that enhance alcohol use in the population generally, or in a part of it (eg, in males alone), are reinforced by genetic factors.

• The greater disposition of males than females to become alcoholics is in part determined genetically, in a manner separate from ordinary familial determination of alcoholism.

Some of the current research effort on the inheritance of alcoholism is a quest for mechanisms that might influence the development of the condition. Here are some findings, based mostly on comparisons between males whose immediate family history does and does not include alcoholism:

• The groups do not differ in the absorption, distribution, and metabolism of alcohol.

• Children of alcoholics, on average, report less intoxication after a given dose of alcohol and show smaller effects of alcohol on physical performance.

• Children of alcoholics demonstrate brain activity consistent with impaired ability to focus attention on their surroundings, with or without alcohol.

• Children of alcoholics have brain activity suggestive of lower levels of relaxation without alcohol and a heightened relaxation after alcohol use.

Thus, heredity may make children of alcoholics less sensitive than others to negative effects of alcohol and more sensitive to its pleasurable effects.

Little consideration has been given to the genetic basis for the sex difference in the prevalence of alcoholism. Women appear to metabolize alcohol more quickly than men, but this difference might be expected to contribute to reduced rather than increased sensitivity to alcohol, and thus to greater rather than less alcoholism among women.

Work at Washington University, St Louis, Missouri, and the University of Umea in Sweden has identified three genetic types of alcoholism. One, characterized by mild abuse, expresses itself equally in men and women. The other two, characterized by moderate or severe abuse, express themselves as familial alcoholism in males but as increased "somatization" in females — eg, recurrent disability from headache, backache, and vague abdominal symptoms, and, in daughters of severely abusing fathers, psychiatric complaints.

A reasonable conclusion from currently available data is that children of alcoholics begin life with some built-in disadvantages. Moreover, no compensating advantages in their genetic make-up spring to mind, although this possibility has not been investigated. Even taking into account the increased risk of alcoholism, the genetic burden carried by children of alcoholics may be small in comparison with the cost of being brought up with an alcoholic.

I'll consider this possibility next month, and discuss too why growing up with an alcoholic parent may not dispose a child to later alcoholism and why women are leading the growing interest in children of alcoholics.

By Richard Gilbert

INTERNATIONAL

Multi-national traffickers the target

Commonwealth drug police to upgrade skills

By Thomas Land

LONDON — The Commonwealth has launched a vigorous training scheme for senior government officials in a global campaign to fight commercial crime such as drug trafficking.

The program includes workshops for lawyers, police, and administrators in Canada, Australia, Barbados, Hong Kong, and elsewhere.

Economic crime has emerged as an expanding international issue. Criminal rings — the Mafia, Triads, Yamaguchi, and others associated with narcotics smuggling, protection rackets, and prostitution — have diversified into many activities.

Now, they use their wealth to fund every kind of criminal operation, infiltrating businesses, corrupting officials, and draining the economic wealth of countries — even undermining political stability and social cohesion.

The training project has evolved through discussions by Commonwealth finance and law ministers representing 49 countries with a combined population of 1,000 million.

A specialist spokesman for the Commonwealth Secretariat here explains: "The large profits generated by organized crime, particularly trafficking in illegal drugs, provide the capital and incentive to operate on an international scale. Profits derived from such activity are frequently laundered and invested in legitimate enterprises or used to fund other illegal activities.

"Small developing countries are particularly at risk. Some national economies are coming under such attack from organized crime that their political, economic, and social institutions are being weakened or corrupted. A small developing country may thus find itself challenging a power considerably greater than its own."

One courier had $160 million issued by a Pacific bank controlled by a North American drug criminal

The Commonwealth training program is a joint project of the Secretariat and the Crown Agents, a public commercial agency of the British government promoting economic development in poor countries. The Secretariat established a specialist unit early this decade to fight international economic crime.

The unit, recently expanded and run by an international team, has received more than 700 requests for investigatory and intelligence assistance. It has been instrumental in the recovery of huge sums of money.

For example, a Commonwealth jurisdiction inquired about a courier found in possession of letters of credit for $160 million. These had been issued by a Pacific bank controlled by a figure prominent in North American organized crime. The documents were part of a scheme to launder profits from narcotics trafficking. The inquiries led to prosecution and conviction.

The unit's success confirms the belief of enforcement agencies that identifying the flow of illegal funds is the most effective way of confronting crime (**The Journal**, March, 1986).

Such investigation on a global scale necessitates specialist skills not available in most poor countries, hence the Commonwealth training program.

Workshops in Hong Kong and Sydney explore the risks and remedies of international crime: a workshop in Fiji focuses on the impact of organized economic crime on small states; and, in Toronto, the subject is laundering and fraud in the security markets. Programs for Barbados and Zambia concern risks of economic sabotage and fraud in international trade including narcotic smuggling.

Tobacco ads, sales promo gradually being cut: WHO

By Thomas Land

GENEVA — Moves toward a total ban on cigarette advertising and sales promotion in mass media are gathering momentum, says the United Nations World Health Organization (WHO) after a global survey.

Tough new advertising restrictions are currently being introduced or are under serious consideration in the United States, Britain, Argentina, Australia, Brazil, Hong Kong, New Zealand, and South Korea. Additional restrictions have recently come into effect in the Netherlands, Sweden, and Singapore.

Canada has banned such advertising by January, 1989 (**The Journal**, June).

Curbs on cigarette advertising and promotion are also being actively studied by the six-nation Gulf Cooperation Council in the Middle East, says *Tobacco Alert*, a specialist publication of the Geneva-based WHO. And in Africa, a total media ban on tobacco advertising has just come into effect in Gambia.

The role of the media in resolving conflicts of interest in global issues is crucial. The ad ban has emerged as a key issue in public health administration, declares a front-page editorial in the WHO publication, "because one of the most powerful weapons the (tobacco) industry possesses is its huge advertising budget.

"By threatening to withdraw advertising, companies have been able to keep a muzzle on the press in many countries.

"Furthermore, tobacco companies are also adept at using advertising to help launch and sustain campaigns of disinformation. In this way, public education programs of national governments are constantly undermined.

The journal quotes the testimonials of a distinguished group of United States medical and media experts given at recent congressional hearings.

C. Everett Koop, MD, United States Surgeon-General, said advertising plays a potent part in recruiting new smokers, particularly children and adolescents. Alan Blum, MD, former editor of the *New York State Medical Journal*, said fear of losing advertising revenues causes many newspapers and magazines to remain silent on the health risks of tobacco.


Paper's cigarette ad ban symbolic attack on industry

By Angela Mangiacasale

Hong Kong's smoking prevention policy works

Habits change significantly within the first two years

By Lachlan MacQuarrie

Applause to cause

a bans all tobacco advertising

n is another target

In **The Journal**: *the tobacco ad debate*

As one of several Canadian newspapers to refuse advertising, *The Globe and Mail*, Toronto, was quoted. In an editorial, the paper said it no longer accepts tobacco advertising and referred to the Canadian Code of Advertising standards which forbids advertisements to "depict situations which might encourage inappropriate, unsafe or dangerous practices" (**The Journal**, October, 1986).

Pharmacists wary of needle exchange plan

By Pat McCarthy

AUCKLAND, NZ — Intravenous drug abusers will be able to buy needles and syringes from chemicists' pharmacies in exchange for used ones under a scheme launched by the New Zealand government to combat the spread of AIDS.

But, many pharmacists are reluctant to take part because of potential health risks to staff and to the public through having drug users on their premises and because of the possibility of contamination.

The health department says special "sharp boxes" placed in the participating pharmacies for addicts to put their dirty needles in when they obtain new ones will help.

The containers have one way openings and, once full, are collected and burned, said John Martindale, leader of the department's communicable diseases project.

The government expects chemists to take a major role in AIDS prevention by supplying health education material and giving treatment advice to drug users.

Commissioner of Police Mel Churches says he fears supplying fresh needles to IV drug users might lead to an increase in abuse.

But, Minister of Health Dr Michael Bassett said the government is telling the drug community: "Don't inject; seek treatment. But if you do inject, never share needles; buy your own."

HOWELL

After AIDS

Acute bacterial endocarditis, brain abcess, septicemia, hepatitis, subacute bacterial endocarditis: these are just a few of the diseases that intravenous (IV) drug addicts have been dying from over the years, for want of sterile needles for self-injection.

From time to time, soft-headed, soft-hearted do-gooders have suggested that if we were to make sterile needles and syringes available to IV drug users, they would be less likely to get sick and die from infectious diseases. Such suggestions have always been viewed with horror by hard-headed, hard-hearted pragmatists eager to explain that the provision of sterile needles and syringes would just encourage IV drug users in their noxious, anti-social habits.

What a difference AIDS makes. In the pre-AIDS era, the only victims of dirty needles were the users themselves, and dirty needles were part of the natural de-selection process; if an overdose of drugs didn't get the junkie, an overdose of bugs would. In either case it was *au revoir*, good riddance, and, 'It serves you right.'

But in the post-AIDS era, the de-selection doesn't just stop with a few addicts sharing a contaminated needle and paying for the consequences with their lives. AIDS allows addicts not only to de-select themselves, it allows them, in the words of the telephone ad, to 'Reach out and touch someone' and in the process of that touching, either by way of blood transfusions or a chain of sexual contacts, de-select (kill) all sorts of people, not only the relatively innocent, but also the truly innocent.

And lo and behold, now just about everyone thinks it is a wonderful idea that IV drug-users have all the best equipment, if not brand-new disposable needles, then sterilizing kits to keep the old reusable needles microbe-free.

Yes, what a difference AIDS makes.

Can you remember back to the pre-AIDS era, back to the time when muddle-headed persons who meant well were always suggesting that teenagers should be given instruction in birth control and sexual hygiene? Allegedly, this would decrease unwanted pregnancies, forced marriages, school drop-outs, and venereal disease.

If you can remember that far back, you can remember what the straight-thinking people had to say about such harebrained schemes: 'They're doing too much of it as it is, and we're not going to make it easier for them to get away with it.' If they're going to play, they're going to have to pay, was the attitude, and there wasn't much the muddle-heads could do about it.

The straight-thinkers made sure that schools kept discussions of sexual activity on a proper theoretical plane, if such discussions were allowed to occur at all. The straight-thinkers didn't have Reason on their side at all times, but they had something better: God. He was allegedly pleased with unwanted pregnancies, forced marriages, school drop-outs, and venereal disease, and diametrically opposed to anything that threatened to oppose this natural order.

But then, along came AIDS. And lo and behold, it turned out that, well, God was a relativist after all. Not a muddle-head, mind you, but a practical deity nevertheless, practical enough that He was willing to endorse the use of Dr Condom's invention by The Guilty if it was the only appropriate means of protecting The Innocent.

I met one of those straight-thinking, pre-AIDS thinkers the other day, and he surprised me by telling a joke. It was about two little kids. The one kid says to the other, 'I found a condom on the veranda yesterday.' The other kid says: 'What's a veranda?'

My straight-thinking, pre-AIDS friend thought that was a pretty good joke. I thought it was a pretty good joke too.

And later on, when I ruminated about it, my ruminations were exclusively concerned with the etymological fact that veranda truly is no longer part of the vernacular and is not a word that one would expect a young person to be acquainted with: deck, yes; porch, maybe; veranda, no. Condom, on the other hand, appears most definitely to be part of the vernacular.

Welcome to the post-AIDS era.

By Wayne Howell

NEWS AND COMMENT

Alcohol/health links require explanation

By Harvey McConnell

CLEVELAND — Moderate amounts of alcohol do seem to have a protective effect against coronary disease, but there are still a number of questions which have yet to be answered.

Arthur Klatsky, MD, chief, division of cardiology, Kaiser-Permanente Medical Center, Oakland, California: "We are becoming a little bit more convinced that the best explanation available at the present time, and perhaps the simplest explanation of the alcohol-coronary disease data, is that this will prove to be a protective effect.

"I think we as health professionals need to deal with this with the general public, and I have felt the best way for us to do so is probably to explain the evidence as clearly as possible."

Dr Klatsky, in a report to the annual meeting of the American Medical Society on Alcoholism and Other Drug Dependencies here, noted that the epidemiological evidence does not suggest large amounts of alcohol have any real health benefits, even if the coronary heart disease incidence is lower in heavy drinkers. This is counterbalanced by the other adverse effects of heavy drinking.

"But, the big unanswered question is what is the upper limit of safety or possible benefit? And, the even more difficult question is what should non-drinkers be advised to do," he added.

Most of his patients do not have problems with alcohol; for those who do, he advises, on an individual basis, that there are a number of better ways to prevent heart attacks than drinking. Overall, one should consider separately the effects of alcohol on cardiomyopathy, hypertension, coronary disease, and stroke.

Flow of US funds tied to legal drinking age

WASHINGTON — The United States Supreme Court has upheld the right of Congress to withhold highway construction funds from four states yet to raise their legal drinking age to 21.

The seven-to-two decision said Congress — in its 1984 Act — was acting within the US Constitution even though it has no direct right to force states to set a legal drinking age.

A Supreme Court justice said Congress had been trying to address the problem of youthful drinking and driving in ways reasonably calculated to advance the general welfare.

Funds have been withheld from South Dakota, Colorado, Ohio, and Wyoming, although South Dakota and Colorado are now about to fall into line.

INSIDE OUT

You really can't go home again

Here I am, sitting and minding my own business, and I'm feeling perplexed, because I'm not feeling anything at all.

I'm back in 'class' again, looking around at the newcomers straggling in to begin their first morning in the same rehabilitation program I was part of almost three years ago.

My plan is to take the program over again, go all the way with it for the purposes of a book I am writing.

The same staff who had steered me through it — with such patience, with such caring — are still here, and they've graciously taken up my idea and allowed me back in again.

I want to see if I can revive, somehow, some of the things I was going through when I walked through the doors of this clinic after my life had fallen to pieces.

I think it might prove useful to others. I frankly expect the insights to pour out — now that I'm seemingly on the other side of the Berlin Wall that separates practising addicts from recovering addicts — if I watch carefully how another group of people deal with their present situation of starting right at the bottom and going through all the minefields that lie on the scary roads ahead of them.

Yes, I'd told myself at home as I geared up my mind for the next three weeks in the clinic, it will be fantastic, all right, to see the process through clear eyes, to feel it all again: the initial shame and remorse, the terrifying but necessary humiliation that precedes the way to a real self-respect, the small but precious triumphs of will.

It will be just fantastic, my writer's fevered imagination has told me, to go through therapy once again, to learn how to relax, truly relax, to see some of those illuminating films on addiction, to hear counsellors laying it all out — the rules and the joys of a life of sobriety — like maitre d's presenting their customers with the greatest menu in the world.

I'm seemingly on the other side of the Berlin Wall separating practising/recovering addicts

I had felt so much, that first time here. And although I have tried my best, my sincere best, to write in this column about how shattering it had been for me, and the other people I'd been in the program with, I still believed I may have missed something crucial, some keys needed to unlock that gigantic door of addiction.

Perhaps, now I would finally have the perspective and the distance from the experience that is needed to turn a writer's corner. I would be able to get it all down, and this thing that has obsessed me, this tremendous mystery of sobriety that descended so preciously into my poor life, would be made clear at last.

I remember last night, hours before I arrive for this first morning, to sit here now in the same chair I'd used the first time around. My mind in flames, I couldn't wait to come, with my pens and paper, my preconceptions, my overwhelming eagerness to take the plunge again into the deep end. It goes without saying, I guess, that I couldn't — didn't really want to — get to sleep. . . .

Now, I introduce myself to a few of the people in the program, tell them I'm back after almost three years because I'm afraid that I'm going to crash again. (This is the agreed-upon rationale the counsellors and I have worked out for my being here.) They don't blink: they have their own problems.

I listen to the introductory chat by one of the counsellors. I hear the words 'anger,' 'depressed,' 'scared.' I read the things we've been given, the schedules, the pamphlets, the regulations. I am given the meal vouchers, I try the coffee again. (How many cups had I had the first time? Uncountable.) I go to look at the fish tank, I look at the bulletin board, I say hello to other counsellors. I try it on for size.

But nothing happens. Nothing at all. I feel bored, bored beyond the telling of it. There are no big insights. No giddy highs and lows. There is no way — I suddenly realize, maybe *this* is the illumination — I will ever feel plugged in again.

That is a once-in-a-lifetime affair.

Someone says something after the introductory chat, when we're by ourselves. What he says sounds so stupid, I almost break in to tell the man a few home truths. But, of course, I don't tell him. I am, after all, in his mind, exactly in the situation he is in now. What, possibly, could I know that was greater than his own knowledge?

There is just no way to connect; the gulf is just too wide. It's not really a question of me feeling superior, either. I know, of all people, how easy it would be to fall over the edge again.

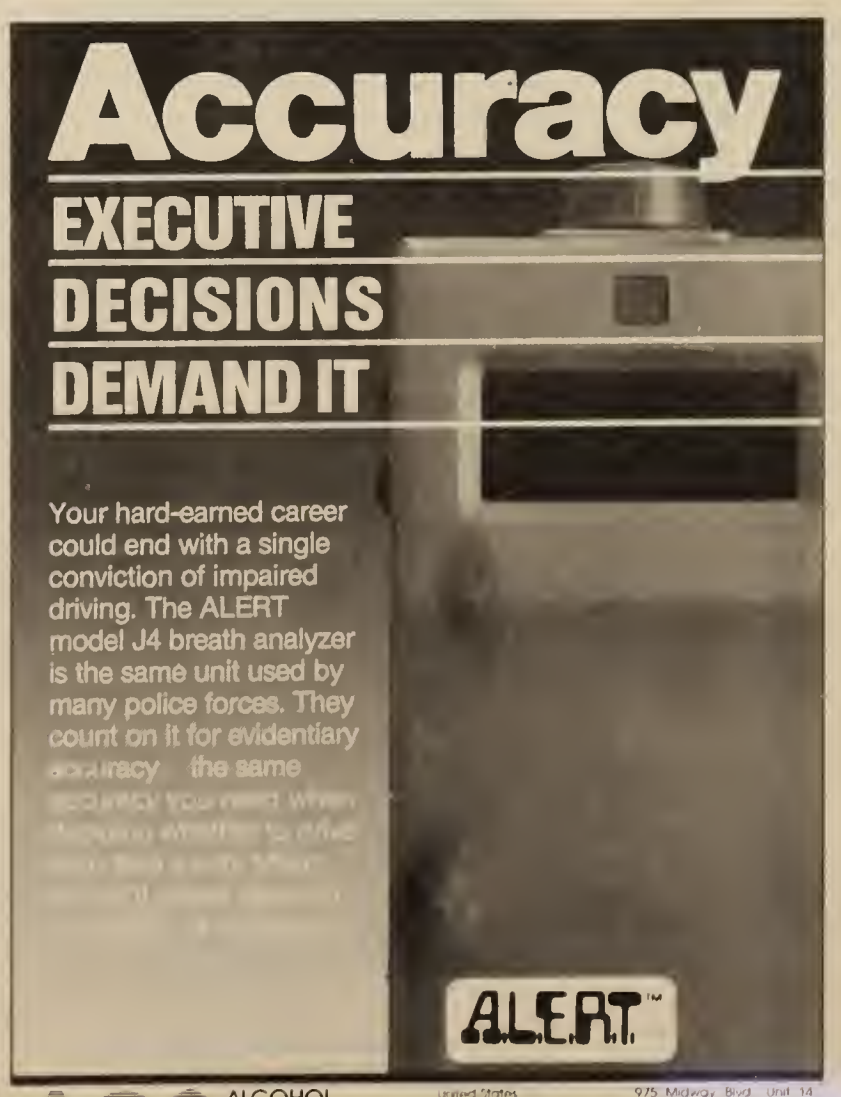
But, I know I don't belong here, and my heart's screaming inside. God, I'd love to tell them what to expect in their lives. . . . Love to say how deeply they're going to hurt, and be opened up in a way they've never been; how much hope they can look forward to, down that long road; how, if they're lucky, love will blossom, love for themselves.

You can't go home again: there's no way I can stay here.

A veteran's memories can never give him back the taste and the smell and the noise and the heart-break of the killing ground.

So, eight hours later, at the end of the first day, I look around at each of the people in the group, and I pick up my pens. I wander away from it all, and all I feel is the wish that they make it, that they find their own keys to the mystery, that they cherish them, protect them, and use them.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.



Coming up in The Journal:

- Harvey McConnell writes on AIDS in Europe
- Reports from the North American Congress on EAPs

NEWS

Lobbyists fight for rights of smokers' relatives

By Maureen Brosnahan

WINNIPEG — Major tobacco companies must be held accountable before the courts for the deaths and damage they cause smokers, says the executive director of a new Canadian lobby group representing families and friends of smokers.

Ronald Hart, executive director of Relatives (and friends) of Dead and Dying Smokers (RODDS), Picton, Ontario, said here that tobacco companies have been getting off free while hundreds of thousands have died from using their products.

"There have been 660,000 deaths in Canada since 1969. These are victims of the deceptive marketing."

Mr Hart, a former smoker and a retired school counsellor whose father and brother both died of lung cancer, said the purpose of RODDS is to encourage relatives and friends of smokers in Canada to take tobacco companies to court and seek compensation.

Relatives (and friends) of Dead and Dying Smokers

Ridge Road, Box 3020, Picton, Ontario K0K 2T0 (613) 393-3030

Sheldon Grimson, a Toronto criminal lawyer and founding member of RODDS, said there is room in the Canadian legal system for such cases.

"There's never been anyone compensated as a result of a lawsuit, and there's never been anyone jailed for peddling this stuff."

He said companies must take responsibility for their products and the health problems caused. "I don't think there's any question that everybody knows cigarettes cause sickness and death. We have proof they (tobacco companies) totally disregard their responsibilities . . . and we want them as defendants in both criminal and civil cases."

Mr Grimson suggested a recent case before the Ontario Court of Appeal involving a large pharmaceutical company sets the precedent for holding a company responsible for health problems resulting from the use of the company's product.

Both Mr Grimson and Mr Hart said their object is not only to tackle the tobacco companies in court, but also to prevent the sale of tobacco to children.

While most provinces have laws prohibiting the sale of tobacco to children less than 16 years, Mr Grimson said they are rarely enforced.

The provinces have to take the first step here, Mr Hart added.

RODDS has about 70 members and Mr Hart travelled across Canada to work up interest in the group. The group hopes to take on many cases at once to develop a united front against the tobacco industry.

Mr Hart said similar action involving 153 cases is pending in the United States.

'Why is it legal to sell things to use with drugs'

Kids look for paraphernalia answers

By Deana Driver

SASKATOON — Canadian youth want answers on the availability of drug paraphernalia, says a Royal Canadian Mounted Police drug prevention officer.

Sergeant Mike Pelletier told **The Journal** he speaks at 500 gatherings each year and young people ask him about the hypocrisy of Canadian laws.

"The kids are saying: 'How come it's illegal to use drugs and it's legal to sell things to use with drugs?' "

Sgt Pelletier, here for a PRIDE (Parents Resource Institute for Drug Education) Canada workshop, said he took his superior officer into a Montreal paraphernalia shop.

"The clerk showed me three different kinds of mixtures for cocaine and explained how to mix it, what the effects would be."

He is concerned such information can be obtained by anyone and that the shops are often located near high-traffic areas frequented by teens — near the Montreal Forum, record stores, and arcades.

The RCMP drug enforcement branch is examining how 32 states in the United States have outlawed head shops and are enforcing those rules. The branch is working with the Montreal city police and Quebec Provincial Police to identify paraphernalia shops there and to determine if there's a link between the shops and drug traffickers.

Ron Hollingshead, special agent, US Drug Enforcement Administration, said paraphernalia dealers are "the sharks that feed on the carcass but won't claim the kill."

Mr Hollingshead told **The Journal** paraphernalia is a $3 billion business in the US and that federal authorities there have not been effective in handling it.

Paraphernalia is difficult to describe legally, and there have been legal problems in the US — some laws banning paraphernalia sales were found to be unconstitutional and others didn't have "enough teeth," he said.

"If the paraphernalia could lead us to drugs, then we could probably get more teeth," said Mr Hollingshead.

"Defining it is the big problem."

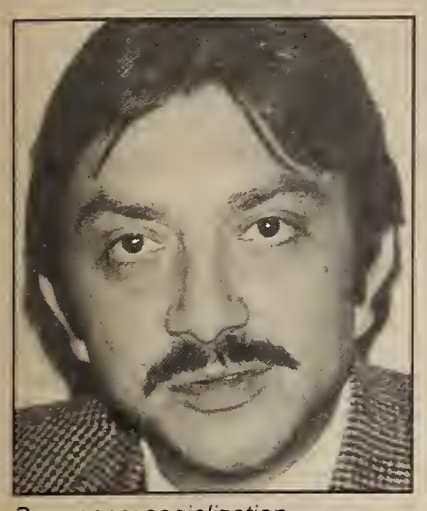
Pelletier: looking for link

Access sought to offence records

WASHINGTON — The Unted States department of transportation is seeking authorization to search a US national computer bank to see if airline pilots and tram operators have records for drunk driving or other serious offences.

The data are compiled by states and maintained by the department of transportation. Since 1982, bus and truck companies have had access to the bank while railroads and the Federal Aviation Administration have not

REVIEWS



Berruecos: socialization

Course tips could help treatment of immigrants

By Neale MacMillan

MEXICO CITY — In an effort to help educate Mexicans about controlling alcohol abuse, a private Mexican institution, the Centre of Psychiatry and Clinical Neurophysiology (CEPNEC), has prepared a prevention program, *Alcoholic Drinks and Health*.

CEPNEC member, Rafael Velasco Fernandez, under-secretary for higher education and scientific investigation, said one version of the course, for rural Mexican teachers, is well suited for a particular audience in Canada — recent immigrants and refugees from Central America. These people have drinking habits similar to those of rural Mexicans: within the community, there is a high incidence of alcoholism and related problems, said Dr Velasco Fernandez.

The program is based primarily on The Power of Positive Parenting, from the *Decision and Drinking* series of the United States National Centre for Alcohol Education and, secondly, on *Your Health and Alcohol*, published by Ontario's Ministry of Health. Materials on alcoholism from Chile and Spain were also used.

These elements were translated into Mexican-style Spanish and adapted to suit the socio-cultural environment of Mexico, said Luis Berruecos, a Mexican anthropologist and CEPNEC member.

There are an estimated two million Mexicans, representing 5% of the population, who can be considered alcoholics, said Dr Berruecos. It is a growing problem rather than a diminishing one.

CEPNEC officials regard the program as part of a prevention strategy which attempts, in part, to reach children through their principal leaders — parents and teachers — in a process of "socialization" about alcohol consumption and related problems.

The officials believed initially it would reach a wide public; after first trials, they realized the audience was limited to primary and secondary school teachers and parents from the middle- and upper-classes, educated at least to the university-entrance level.

The course text for this audience begins with a set of questions/answers meant to measure a participant's knowledge of alcohol and its effects. Participants are evaluated on the number of correct responses.

A separate course intended for rural teachers is presented in a condensed, simpler text. Many rural teachers themselves have problems with alcohol, so such a course will benefit them as well as their students, said Dr Berruecos.

New Books

by Margy Chan*

Drugs and Aging

. . . by William A. McKim and Brian L. Mishara

The elderly receive more prescribed drugs and purchase more over-the-counter medication than any other age group. As a result, misuse or abuse of drugs among this population is a potential problem.

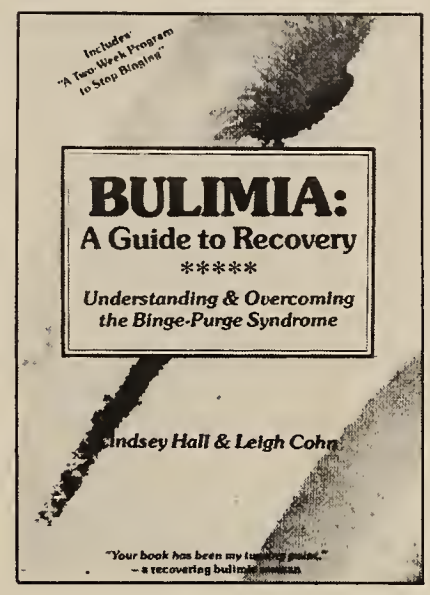
This book is written for professionals: nurses, social workers, physicians, pharmacists, gerontology students, and researchers — and for older adults and their relatives. It addresses age-related processes and problems from a social science, rather than a medical or pharmacological, perspective.

The authors emphasize the importance of considering individual differences in the use and effects of drugs associated with physiological, anatomical, or health changes that accompany age.

A considerable amount of epidemiological data in Canada is included.

This is a monograph in the *Perspectives on Individual and Population Aging* series; as in all monographs in the series, it concludes with a proposed agenda for research and policy directions needed in Canada.

Butterworths, Scarborough, Ontario, 1987. 133 p. $15.50. ISBN 0-409-80517-3.



. . . by Lindsey Hall and Leigh Cohn

Bulimia is a food obsession characterized by: repeated overeating binges, followed by purges of forced vomiting, prolonged fasting, or abuse of laxatives, enemas, or diuretics. It is now recognized as a metal disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III).

The book is divided into three main parts: Understanding Bulimia answers often-asked questions and includes the author's own experiences; Overcoming Bulimia offers motivation, support, inspiration, and specific things to do instead of binging; the third section contains appendices with more specific guidelines and resources.

Gurze Books, Carlsbad, California, 1986. 159 p. $11.95. ISBN 0-936077-05-0.

Dealing with Drugs: Consequences of Government Control

. . . edited by Ronald Hamowy

This collection of papers on illicit drugs and government control was written by leading psychiatrists, criminologists, pharmacologists, and economists. The authors stress the failure of existing laws to control illegal drugs. The current drug problem in the United States has not diminished despite: "draconian legislation and repeated declarations of 'war on drugs.' "

While the authors criticize current drug enforcement policies, they also suggest a range of options for reform, including the development of alternative private solutions for social control of drug use and abuse.

This is a monograph in Pacific Studies in Public Policy, from the Pacific Research Institute for Public Policy, San Francisco, California.

Lexington Books, D. C. Health & Co, Lexington, Massachusetts, 1987. 385 p. $40. ISBN 0-669-15678-7.

Books received

Keeping Promises: The Challenge of a Sober Parent — Kay Marie Porterfield. Harper & Row, San Francisco, California. 1984. 145 p. $6.95. ISBN 0-06-255441-7.

** Margy Chan is manager of the Addiction Research Foundation's library, the leading library in the field worldwide. A graduate of the University of Hong Kong, she holds a master's in library science from the University of Toronto.*

Career opportunities

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The Journal, Addiction Research Foundation, 33 Russell Street,
Toronto, Ontario Canada M5S 2S1 (416) 595-6123

ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Seniors and Alcohol Abuse

Number: 795.
Subject heading: Alcohol and the older.
Time: 25 min.
Synopsis: Two older people recount their reasons for drinking and how, after retirement, they quickly became alcoholic. Health professionals explain why it is often difficult to diagnose alcoholism in the older: it is important to pay attention as increasing numbers of the older experience alcohol problems.
General evaluation: Poor to fair (2.9). The film contains good information, but the format is boring.
Recommended use: With a resource person, the film could be used with the older, their families, and health professionals.

Cocaine to Crack: Gina's Story

Number: 783.
Subject heading: Cocaine; drugs and youth.
Time: 23 min.
Synopsis: Matt learns that Gina, an ex-girlfriend, has died from a cocaine overdose. He recounts how they first used cocaine at a party; Gina, usually shy, found the drug made parties enjoyable. As her drug use escalated, her relationship with Matt deteriorated. Matt's parents discovered he had been selling things to buy the cocaine; they forced him to go to a drug treatment centre. Gina began to use crack; Matt saw Gina rarely and eventually left town. Her death brings him back to the drug therapy centre to talk about his feelings and to offer to help.
General evaluation: Poor to fair (2.7). The scene in the treatment centre appears contrived; the acting is poor and would probably not keep the attention of the intended audience.
Recommended use: With a resource person, the film could be used with young people 15 to 18 years old.

Drugs and Driving: Double Trouble

Number: 800.
Subject heading: Impaired driving.
Time: 20 min.
Synopsis: The public is aware generally of the hazards of drinking and driving; however, many do not realize it can be equally dangerous to use other drugs and drive. Drivers say drugs like cannabis, cocaine, and antihistamines do not affect ability to drive. Under the influence of the various drugs, the same drivers then clearly show impairment while playing driving-simulation video games.
General evaluation: Good (4.1). This contemporary, well-produced film includes good information about drugs and driving; it could lead to attitudes opposed to drug use. General broadcast is recommended.
Recommended use: With a resource person, the film would benefit those in driver-education programs.

Welcome to the Parade

Number: 794.
Subject heading: Drugs and youth.
Time: 85 min and 48 min.
Synopsis: This is the story of Michael, a university student living at home and having trouble coping with his family. He uses pot to relieve stress; when his parents find out, they are angry. Michael is urged by friends to go away for a few days to let things cool off. When he returns, things are no better, and he leaves for good. While living in a cheap room, he befriends a prostitute and uses her connections to start dealing in cocaine. A pusher finds out Michael has cut the cocaine with baby powder and has him beaten up. Michael gets to a hospital: when he recovers, he returns home to his family.
General evaluation: Poor (2.0 for 85-min version; 2.4 for 48-min version). The 85-min version seems long and boring: the story line is inconsistent, and the character development is poor. The film offers no solutions to the family's problems. The 48-min version is disjointed and difficult to follow.
Recommended use: The film could be used with those 18 years of age and older.

Portrait of a Teenage Drug User

Number: 801.
Subject heading: Drugs and youth.
Time: 23 min.
Synopsis: Teenagers who've had drug problems talk about their experiences: why they first tried drugs, how they generally felt good, and how they wanted to continue. As use increased, they had problems with school, home, social relationships, and, some, legally. Eventually, their lives became so unmanageable, each decided to seek help. They are now recovering and trying to rebuild their lives.
General evaluation: Good to very good (4.9). The young people's stories follow a natural progression from use to abuse, to treatment and recovery. The young people are believable and articulate; audiences will quickly become emotionally involved. General broadcast is recommended.
Recommended use: With a resource person, the film would benefit young people in treatment, parents, and general audiences.

Counselling For Relapse Therapy Part 1: Overview of Relapse Theory

Number: 799.
Subject heading: Treatment/rehabilitation.
Time: 60 min.
Synopsis: Many people do not succeed when they first try treatment for addiction problems. Many therapists blame patients for such relapses when, in fact, the treatment is inadequate. Most therapy procedures do not meet the needs of relapse-prone patients. It is important to recognize such patients, symptoms of impending relapse, and to be prepared to use relapse-prevention therapy.
General evaluation: Poor to fair (2.6) The lecturer has good information, but the format detracts from the message.
Recommended use: The film could be used with health professionals.

Whose Problem Is It?

Number: 803.
Subject heading: Employee assistance programs (EAPs).
Time: 25 min.
Synopsis: On the way to work, Terry and Mike discuss Terry's personal and financial problems. Mike is also concerned that Terry smokes 'pot' at work. Terry's boss confronts him over his poor work record, lateness, and absenteeism, suggesting he see the EAP counsellor; Terry refuses. Next day, Mike persuades Terry to promise he will not smoke up. Terry sneaks a joint and almost runs down another worker with a forklift. Terry's boss tells him to seek immediate help or lose his job; Terry goes to the EAP counsellor and agrees to join a therapy group.
General evaluation: Fair (3.1). While the film shows many aspects of a good EAP, it is overly long. Some scenes seem contrived and do not hold attention.
Recommended use: With a resource person, the film could be used as general education for companies with an EAP.

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Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Pharmacology and Drug Abuse: A Multimedia, Distance Education Course — Sept 16-Dec 16 Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Early Diagnosis of Addictive Disorders — Sept 26, Toronto, Ontario. Information: James Brodie, media relations, Bellwood Health Services Inc, 1020 McNicoll Ave, Scarborough, ON M1W 2J6.

Canadian Association of Addiction Counsellors Fall Workshop: Case Management — Sept 29, Toronto, Ontario. Information: Bill Vine, community services, George Brown College, 2 Murray St, Toronto, ON M5T 1T6.

Health Promotion Workshop: Health Promotion Insights and Innovations — Oct 1, Toronto, Ontario. Information: Alison Stirling, Parkdale Community Health Centre, 1257 Queen St W, Toronto, ON M6K 1L5.

Current Trends in Addiction — Oct 3, Oct 22, Windsor, Ontario. Information: Iona College, United Church of Canada, Affiliate of the University of Windsor, 208 Sunset Ave, Windsor, ON N9B 3A7.

Introductory Addictions Management Course — Oct 5-7, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Public Forum: Mixed Reactions — Seniors, Alcohol, and Drugs — Oct 8, Toronto, Ontario. Information: Donna Heughan, special events, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

AIDS: A Holistic Response — Oct 15-16, Edmonton, Alberta; Oct 22-23, Montreal, Quebec; Nov 12-13, Toronto, Ontario; Nov 19-20, Halifax, Nova Scotia. Information: Freda Fraser, director of communications, Catholic Health Association of Canada, 1247 Kilborn, Ottawa, ON K1H 6K9.

Different Groups - Different Needs — Oct 17, Toronto, Ontario. Information: M. Hughes, inservice education, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Aging with Excellence: Social, Mental, Physical, and Spiritual Fitness — Oct 22-25, Calgary, Alberta. Information: Canadian Association on Gerontology, 1080-167 Lombard Ave, Winnipeg, Manitoba R3B 0V3.

Input 87: The 7th Biennial Educational Symposium on Employee Assistance Programs in the Workplace — Oct 25-28, Ottawa, Ontario. Information: Input 87, conference and seminar services, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

Critical Risk - Quality Care: Adolescents in Secure Settings — Oct 27-30, Toronto, Ontario. Information: Roberta Roberts, Thistletown Regional Centre, 51 Panorama Crt, Rexdale, ON M9V 4L8.

Productivity 87: Employee Assistance as a Benefit and Productivity Tool — Oct 28-29, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4RS.

Second Annual Ruth Cooperstock Memorial Lecture: Nuclear Addiction - Oct 29, Toronto, Ontario. Information: Patricia G. Erickson, head, drug policy research, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Drug Education Coordinating Committee 1987 Conference, Drug Abuse: Epidemic or Smokescreen — Oct 29-30, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

9th Annual Conference of Substance Abuse Librarians (SALIS) — Nov 3-6, Edmonton, Alberta. Information: Bette Reimer, conference chair, Alberta Alcohol and Drug Abuse Commission library, 10909 Jasper Ave, Edmonton, AB T5J 3M9; or Ginny Rolett, SALIS chair, Project Cork Resource Center, Dartmouth Medical School, Hanover, New Hampshire 03756.

Children of Alcoholics: A Mini-Conference — Nov 5, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Public Forum: IV Drug Use and AIDS — Nov 12, Toronto, Ontario. Information: Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

United States

Alcohol and Drug Problems Association: Professional Excellence The Perpetual Challenge — Sept 20-23, St Louis, Missouri. Information: ADPA, Jeffrey Kramer, 4440 N Capitol St NW, Ste 181, Washington DC 20001.

Cape Cod Symposium on Addictive Disorders: Intervention and the Family, An Opportunity for Dialogue — Sept 24-27, Hyannis, Massachusetts. Information: Fred French, conference coordinator, North River Counselling Inc, 475 Furnace St, Marshfield, MA 02050.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Oct 3-7, Chicago, Illinois. Information: Thomas J. Delaney, executive director, ALMACA, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

American Medical Association: 8th National Conference on Impaired Health Professionals — Oct 8-11, Chicago, Illinois. Information: Janice Robertson, AMA, Dept of substance abuse, 535 N Dearborn St, Chicago, IL 60610.

A Day with David Smith on Cocaine and Alcohol — Oct 9, Chicago, Illinois. Information: Myra Nichols or Cathy Moynihan, Interventions, Professionals for Counselling and Education, 1234 S Michigan Ave, Chicago, IL 60605.

National Commission on Accreditation of Alcoholism and Drug Abuse Counsellors Credentialing Bodies — Oct 17, Wilmington, Delaware. Information: Patrice M. Muchowski, c/o Adcare Hospital, 107 Lincoln St, Worcester, MA 01565.

New Directions in Chemieal Dependency — Oct 17, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

115th Annual Meeting American Public Health Association — Oct 18-22, New Orleans, Louisiana. Information: American Public Health Association, 1015 15th St, NW, Washington, DC 20005.

Freedom 87: Geisinger National Conference on Addiction — Oct 28-Nov 1, Philadelphia, Pennsylvania. Information: Alan D. Hulsman, Freedom 87, c/o Marworth, Waverly, PA 18471.

AIDS and Chemical Dependency: Multidisciplinary Approaches — Nov 7-8, San Francisco, California. Information: Mim Landry, Haight-Ashbury education group, 409 Clayton St, San Francisco, CA 94117.

Association for Medical Education and Research in Substance Abuse Annual Meeting — Nov 10-13, Rockville, Maryland. Information: AMERSA conference coordinator, Brown University Center for Alcohol and Addiction Studies, Box G, Providence, Rhode Island 02912.

Southeastern Conference on Alcohol and Drugs 1987 — Dec 2-6, Atlanta, Georgia. Information: Charter Medical Corporation, addictive disease division, Box 209, Ste 701, Macon, GA 31298.

Abroad

Alcohol 2000 — Sept 21-24, Coventry, Great Britain. Information: Judi Ofori-Boateng, Alcohol 2000, Alcohol Concern, 305 Gray's Inn Rd, GB-London WC1X 8QF.

Sucht 87 — Nov 2-5, Osnabruck, Federal Republic of Germany. Information: Deutsche Haupstelle gegen die Suchtgefahren, E. Gocke/DHS, Postfach 1369, D-4700 Hamm 1, Fed Rep Germany.

International Symposium on Alcoholism and Drug Addictions Among Seafarers — Nov 4-6, Vigo, Spain. Information: Xose Teixeiro, coordinator cientifico, Casa del Mar/Orillamar, 51, E-36202 Vigo (Pontevedra), Spain.

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Japan Convention Services Inc, Nippon Press Center Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.

Alcoholism and Other Dependencies — Nov 22-25, Warsaw, Poland. Information: C. Godwod-Sikorska, Institute of Psychiatry and Neurology, Sobieskiego 1-9, PL-02-957 Warsaw, Poland.

9th International Conference of the Non-Governmental Organizations for the Prevention of Drug and Substance Abuse — Nov 23-27, Hong Kong. Information: Conference secretary, 9th NGO conference, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

Golobitsh

Suicide. The word has many connotations for those in the addictions field.

For those working in treatment, there is concern for clients; for those working in research, there are epidemiological and etiological questions. In policy, prevention, and education, there is the need to communicate. But, what? How? And to whom?

A National Task Force appointed by Health and Welfare Canada has been studying suicide for more than six years; this summer, the group released a report, *Suicide in Canada*.

Managing editor Elda Hauschildt examines addiction-related issues in the report.

OTTAWA — More than 1,000 people around the world commit suicide every day, the United Nations World Health Organization estimates. Several million people attempt suicide every year.

Suicide ranks among the top five to 10 causes of death in North America and most European countries.

In Canada, epidemiological studies show the suicide rate — 1983 statistics peg it at 15.1 per 100,000 — has been increasing since the Second World War, especially among men. Canada's annual rate is now higher than it is in the United States and many European countries.

Between 1963 and 1976, more than two million years of life were prematurely lost in Canada because of suicide.

"What makes these figures even more alarming," says the Canadian National Task Force on Suicide, "is the probability that under-reporting results in a significant underestimation of the true magnitude of the suicide phenomenon."

In its report, *Suicide in Canada*, released this summer, the Task Force notes suicide is an action, not an illness; identifying the chain of causal and triggering factors — and coming up with prevention and treatment strategies — is "perhaps one of the most vexing problems facing professionals in the health sciences.

"And yet, immediate action is necessary even in the face of imperfect knowledge."

The Task Force makes 40 recommendations on prevention, intervention, and postvention (eg, psychological autopsy). And, it identifies Canadian high-risk populations: those with certain mental disorders, alcoholics, young people, the elderly, Native peoples, people in custody, and the bereaved. Alcohol and other drug use are contributing factors for three of these groups — young people, the elderly, and Native peoples — as well as, obviously, alcoholics.

"In general," the Task Force says, "an increasing incidence of alcoholism has been noted among individuals who commit suicide. This association warrants the inclusion of alcoholics in the high risk category.

"Strategies of prevention and intervention acknowledge the complexity of the relationship, particularly with regard to the overlap with depression and other mental disorders."

The Task Force relates suicide to indirect, self-destructive behaviors: "chronic substance abuse, hyperobesity, habitual high risk-taking behavior, willful self-neglect by the elderly, and non-compliance with the treatment of serious illness."

To what degree the cause and treatment of such behaviors share a common basis with suicide, it says, is "a matter of debate." But, recognizing the self-destructive and suicidal aspects of these behaviors is crucial for effective diagnosis and treatment.

"Similarly, the prevention of suicide *per se* may be advanced by the study of these related behaviors."

In looking at the etiology of suicide, the Task Force considered both social and medical/psychiatric factors: the literature indicates familial, job-related, ethnic, and social disorganization factors are most important in determining suicidal behavior.

Marital status, family size, and other family-related variables are important familial influences; job-related factors seem to play a greater role in male suicide than in female. And, social disorganization refers to an environment characterized by "undesirable social conditions: crowded living arrangements, low-quality housing, criminality, alcohol and other drug abuse, solitary living, and transient habits."

'It's suggested that addiction workers be trained in suicide assessment'

Canadian evidence on ethnicity, the Task Force reports, is suggested by the "correlation between provincial suicide rates and immigration, particularly females of European origin with a mother tongue other than English or French." As well, Native peoples have a suicide rate two to three times greater than the general population.

In looking at medical/psychiatric factors, the Task Force points out theorists "maintain that an underlying physical process, subject to environmental influences, may be the most important determinant of suicidal behavior." physical illness, mental disorder, alcohol or other drug abuse, stress, and certain biological conditions (menstrual cycle and pregnancy; neurological, biochemical, and genetic factors).

More than 1,000 of the 3,358 documented suicides in Canada in 1980 were alcohol-related. And, United States studies report an alcoholism rate of 8% to 12% among suicides and suicide-attempters, up to twice that of the general population.

"Individuals who attempt suicide were shown to have a higher level of drug use and abuse than individuals who committed suicide. Both suicide completers and suicide attempters were found to use sedatives and tranquillizers on a daily basis more frequently than those who died natural deaths. Actual drug overdoses were more common among suicide attempters than completers."

The Task Force states alcoholism is also a factor in "many sub-intentional suicides, such as cirrhosis of the liver, and indirect alcohol-related deaths, including car accidents, fires, falls, and drownings."

Turning to alcoholics as a high-risk population, the Task Force cites 1980 statistics on 17,974 alcohol-related deaths, including: 2,854 from falls, fires, drownings, homicides, and suicides; 2,700 road fatalities; and, 2,110 from alcohol-related cirrhosis, alcohol dependency syndrome, non-dependent abuse of alcohol, alcohol psychosis, and accidental poisoning by alcohol.

"Reluctance to identify a death as suicide, combined with inconsistencies in certification procedures, may hide an even higher proportion of suicides related to alcohol."

There are specific hypotheses concerning the dynamics of alcohol-related suicide and homicide, says *Suicide in Canada*.

"On the one hand, this process is seen as reducing normal inhibitions to destructive feelings and, in times of stress, impairing judgement to the point where non-destructive alternatives are not perceived.

"On the other hand, alcohol is also seen as being used by individuals to 'find the courage' necessary to follow through with the intention of committing suicide or homicide."

Chronic alcoholism is also "considered to be in and of itself a form of slow suicide, or 'suicide by inches.'"

The Task Force relates frequently reported features of suicidal behavior — a sense of isolation, helplessness, hopelessness, and low self-esteem — as common to alcoholics too: "They often alienate the 'significant others' in their lives, feel helplessly caught up in the stranglehold of physical dependency, and, after frequent treatment failures or experiences of falling off the wagon, are pessimistic about conditions ever improving.

"They may label themselves as 'losers' or as individuals of little value or worth, and those around them may join in this condemnation."

Although alcoholism has been found to be a significant factor in explaining suicide rates for Canadians, the relationship appears to be stronger for males than for females. "However, while studies have investigated the relationship between alcoholism and suicide, the precise nature of the relationship remains a matter of considerable debate."

The Task Force reports three conflicting views:

- alcoholism is a cause of suicide,
- alcoholism is a form of suicide,
- alcoholism and suicide are manifestations of a single cause.

And, it reviews two research methods — looking at the incidence of suicides in groups of alcoholics (10% to 40% in a 1983 study), and determining patterns of alcohol consumption among people who either attempt or commit suicide (steadily increasing to 30% among suicides, says a 1982 study).

"It is generally accepted that pre-existing mental disorders and alcoholism are important determinants of suicide. This does not imply sole causation.

"Although research shows that only a small proportion of suicide victims have been free of psychiatric disorder, reports also point to a large percentage of individuals with mental disorders who do not commit suicide.

"Mental disorder should be considered only as one factor — albeit a significant one — with many other influences such as social, psychodynamic, developmental, and constitutional factors acting in an interactive fashion."

To meet the objective of preventing suicides among high-risk groups in Canadian society, the Task Force report says, "it is critical to move beyond the identification of these populations to specific strategies designed to deal with each group."

For alcoholics, the Task Force concludes that "as with mental disorders, the exact nature of the relationship between alcohol and suicide is subject to debate." It suggests prevention and intervention strategies for alcoholics must acknowledge the complexity of this relationship, particularly the overlap with depression and other mental disorders.

"It is suggested that addictions counsellors and the staffs of detoxification centres be trained in suicide risk assessment." Further, the Task Force recommends that efforts to reduce the incidence of alcoholism be strongly encouraged and that additional government support be considered for agencies treating alcoholics and their families.

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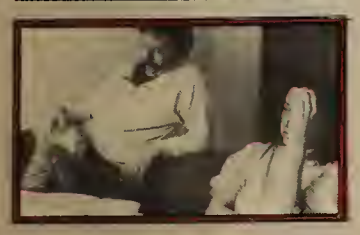
INSIDE



Federal drug strategy follow-up

Archibald studies 'national' options

By Anne MacLennan

TORONTO — H. David Archibald has been asked by Health Minister Jake Epp to identify drug demand reduction programs in Canada that could serve the government's national drug strategy.

At the same time, the government is seeking an "appropriate follow-up vehicle" to coordinate the strategy, a health department official told **The Journal.**

The federal plan calls for a comprehensive and balanced approach to reducing both demand for and supply of drugs.

Mr Archibald, a world figure in the addictions field, served as senior advisor on development of the strategy — *Action on Drug Abuse/Contre les drogues*, which was launched in May (**The Journal,** June).

He will report to Mr Epp by the end of December on "whether and how the cumulative experience and specific programs operated by federal and provincial governments and non-governmental organizations" can be used to serve all of Canada.

Specifically, he will:

- concentrate on demand reduction programs that could — with or without modification — contribute;
- establish the feasibility of generalizing them to Canada; and,
- prepare options for organizational and financial arrangements.

As he began his review, Mr Archibald told **The Journal** it will be limited to programs "that clearly can contribute significantly to achievement of the objectives of the strategy."

The strategy was drawn together by a federal, inter-departmental secretariat in consultation with provincial and territorial governments and non-government bodies. The federal departments involved include health, solicitor-general, national revenue, justice, external affairs, and youth (**The Journal,** July).

Since the launch, there has been a burgeoning of committees of bureaucrats and experts working on implementation approaches, a media blitz aimed at young people, and a national forum scheduled for this month; a media campaign for parents is also in the works.

To date, however, no "linch pin" body has been set up with the authority to pull together the efforts not only of demand reduction officials but also of officials from related supply reduction areas.

Said Mr Archibald: "This whole thing will only work if the provinces and territories and the federal government can work together.

"The degree of coordination and cooperation that exists across the country rests on the degree to which cooperation can be established among the various departments in Ottawa and between that group and the provinces."

Alcoholism drug therapy promising

Effective treatments are 'badly needed'

By Joan Hollobon

TORONTO — Drug treatment for alcoholism has remained stagnant until the last few years, but now faces a real possibility of significant change, says Claudio Naranjo of the Addiction Research Foundation (ARF) here.

Head of the ARF's clinical pharmacology program and associate professor, departments of pharmacology and medicine, University of Toronto, Dr Naranjo says effective therapies are badly needed because alcohol-related problems affect 20% of the population.

But, systematic approaches to developing new pharmacotherapy for alcoholism are confined to a few groups of basic and clinical scientists working in academia, Dr Naranjo told medical grand rounds at the ARF recently.

Outlining current trends in pharmacotherapy, Dr Naranjo cited drugs affecting several aspects of alcoholism: intoxication, withdrawal syndrome, consumption, and medical complications.

Anti-intoxicant drugs have been sought because of the serious medical and social problems resulting from intoxication. For example, it is estimated drunk drivers are responsible for from 25% to 35% of all traffic accidents causing serious injury.

One recently developed drug — Imidazobenzodiazepine (Ro15-4513) — selectively antagonizes alcohol intoxication in rats. It is a "partial inverse agonist at benzodiazepine receptors. Partial inverse agonists reverse the behavioral effects of benzodioazepines." Ro15-4513 blocks ethanol intoxication but without inducing other effects of benzodiazepines, such as a sedative effect.

However, human studies may be prevented by toxicity and ethical concerns.

In high doses, Ro15-4513 can induce severe tremors and seizures in animals, so it could precipitate seizures in people undergoing alcohol withdrawal. Also, it does not reverse the lethal effects of ethanol in laboratory animals and might not do so in humans.

Ethical concerns revolve around use of the drug to permit intoxicated people to drive cars or operate machinery. Dr Naranjo told **The Journal** animals given intoxicating levels of ethanol after pretreatment with Ro15-4513 show no signs of intoxication. No human data exist, but extrapolation suggests people would likely be able to perform various tasks without showing signs of intoxication.

Despite these disadvantages, however, a drug such as Ro15-4513 might be valuable if restricted to emergency treatment, Dr Naranjo suggested. Individuals who most often die from drug overdose are those who have taken a sedative drug plus ethanol; used in combination with sedative antagonists, a drug that selectively antagonized alcohol might enable such a patient to be brought out of an otherwise fatal coma, he said.

Mild or moderate alcohol withdrawal syndrome (AWS) can be treated without drugs in two-thirds of cases by reassurance, reality orientation, frequent monitoring of signs and symptoms, personal attention, and general nursing care. Drugs are necessary, however, in patients in moderate to severe withdrawal, since supportive care cannot prevent seizures, hallucinations, or arrhythmias, Dr Naranjo said.

(See New drugs, p2)

In Amsterdam

Needle exchange hits 700,000 mark

AMSTERDAM — The approach is clear-headed and pragmatic; the aim is to control the spread of the HIV virus in the IVdrug using population and from them to the general public. The results? It's too early to tell, but authorities at the Municipal Health Service here hope to hold back what one clinic worker calls "typhoon AIDS."

At left, Krishna Kanhai, MD, medical director of one of the city's suburban clinics, with boxes of sterile needles and a garbage can filled with dirty needles.

In the first of a series of special reports, The Journal's Contributing Editor, Harvey McConnell, looks at Amsterdam, where 700,000 sterile needles will be distributed this year.

See pages 7/8

NEWS

Briefly . . .

Alcohol babies

SASKATOON — Breastfeeding mothers have been warned to refrain from drinking. Barry Blakely, professor, University of Saskatchewan here, says alcohol is known to suppress the immune system and cautions alcohol can pass into the mother's milk as readily, and in the same concentrations, as it can into the blood stream. He told *The Globe and Mail* studies are now underway to determine if immune factors usually passed from mother to child are suppressed by maternal drinking.

Nuclear worry

LANSING, MICH — Air crews of military planes carrying atomic weapons may be flying in more ways than one, says *Monday Morning Report*. Of the 112,000 people handling nuclear weapons, ahout 5,100 are decertified annually — mostly for drug and alcohol ahuse. The crew of a Prowler jet that crashed onto the flight deck of the nuclear-powered aircraft carrier, *Nimitz*, were found to have used marijuana and amphetamines.

Diverted R_x samples

WASHINGTON — A bill designed to reduce illegal diversion of prescription drug samples has not impressed the United States Congress. But, the US Pharmaceutical Manufacturers Association here has adopted a code of ethics with the same aim, reports *Medical World News*. The code calls for: receipts from doctors who receive samples, samples being locked up, companies performing annual audits and keeping records of who distributes samples, and doctors returning outdated samples to companies for disposal.

Test of success

LONDON — Winning athletes as young as 12 years old will he automatically tested for drugs following tough new legislation here aimed at eliminating drugs from sports. A new independent testing hody, reporting directly to the Sports Council, will cover sports as diverse as caving and tug-of-war, reports the *London Sunday Times*. The government has also outlawed anabolic steroids by including them in the Misuse of Drugs Act which allows criminal prosecutions for possession.

Fair warning

WASHINGTON — Health warnings on cigarette packages are enough to protect tobacco companies from lawsuits, a United States federal appeals court has ruled. *The Globe and Mail* reports the unsuccessful suit was launched by the heirs of a 49-year-old man who smoked up to four packs daily for 23 years.

MDs waiver on AIDS testing/tracing

By Betty Lou Lee

CHARLOTTETOWN, PEI — After almost five hours of debate, the general council of the Canadian Medical Association (CMA) sent its two most contentious issues on AIDS back for further study to its council on health care.

It first approved the principle of mandatory tracing of sexual contacts, then sent the issue back to the health-care council.

Nor would it go for testing all inpatients and outpatients in hospitals. Those who opposed this measure pointed to a cost of millions (from $5 each for a screening test to $100 for a final confirmatory one) and said it would send a message to the public that the AIDS virus is easily transmitted.

Under the usual procedure, the council on health care would bring the issues back to the next annual meeting. But the day after his installation as president, Athol Roberts, MD, Charlottetown, announced he was forming a subcommittee on AIDS to bring the recommendations to the CMA board of directors at its November meeting. The board is expected to issue a policy statement then.

Dr Roberts, a former Baptist minister, said "absolute answers are hard to come by . . . the truth is changing week by week," but the CMA must give strong leadership.

At different times during the debate, the general council passed what some considered conflicting resolutions on the issue of a doctor's ethical responsibility to maintain confidentiality of patient information.

One resolution, carried by a large majority, stated: "It is not unethical to make discreet disclosure to an appropriate person, with the patient's knowledge that such disclosure is being made, when public interest clearly outweighs the interest of the patient."

This would cover the situation when a confirmed AIDS patient, or carrier, refuses to tell a spouse or other sexual partner and refuses permission for the doctor to do so.

But later in the day, with no discussion, a resolution passed that called for the CMA to "stress the need to respect patient confidentiality and, where necessary, the need for legal and regulatory safeguards for such confidentiality."

Less contentious motions called for:

- mandatory non-nominal (using a code, not a name) reporting of patients with AIDS or confirmed AIDS-antibody tests;
- educational messages that state sexual activity is not rendered totally safe by the use of a condom;
- an active public education program that will include the school population;
- more federal and provincial funds for treatment and prevention research and education of health professionals; and,
- appropriate safety measures for handling body fluids and tissues in hospitats, and making those involved directly in patient care aware of the potential risks of infection.

CMA wants more labels

By Betty Lou Lee

CHARLOTTETOWN, PEI —If Canadian doctors have their way, warnings about adverse effects of alcohol and medicines will join warnings about the adverse effects of drinking and driving in alcohol outlets.

At its annual meeting, the Canadian Medical Association (CMA) called for warnings of adverse interactions between alcohol and prescription and non-prescription drugs to be displayed prominently, or distributed, where any of these products are sold and/or dispensed.

The CMA will also urge the Canadian Pharmaceutical Manufacturers Association and the pharmaceutical industry to put warnings about potential interactions with alcohol on both prescription and non-prescription drugs.

Educational programs about drug abuse are also urged for all schools.

The CMA council on health care noted that "costly methods of control have not solved this unfortunate problem" and said its members believe "education about the misuse of drugs is an essential method of prophylaxis that should be further explored."

Cost-effectiveness sells in US

Canadian EAPs focus on human side

By Karin Maltby

SEATTLE — While Canadian corporations want their employee assistance programs (EAPs) to work because workers are suffering, companies in the United States tend to look at cost effectiveness.

"If I were selling an EAP in Canada, I would sell the human aspect of it . . . but in the (US) when you go in to sell a program, the first thing you do is hit them with the dollars and cents.

"So, in the US, you lead with 'I can save you $7 for every $1 you spend;' in Canada you lead with 'I can save you 10% of your population in the next 10 years.' "

Mark Cooper, coordinator of education and research for Bry-Lin Hospitals, Buffalo, New York, attributes this striking difference between Canadian and US EAPs in part to "Canada's paternalistic health-care delivery system."

On the other hand, the US EAP system can refer a person to appropriate treatment only if health insurance funds are available.

Mr Cooper, editor of *The Rush House*, an employee assistance newsletter, and a consultant to industries in both countries, compared the Canadian and US employee assistance movements at the North American Congress on EAPs here.

While Canada's EAPs operate on a system of attraction and word-of-mouth among employees, US programs "are more aggressive. It is a principle of integrating the EAP into the workplace . . . a multi-million dollar business of people selling EAP posters, tapes. . . ."

Neither country is comfortable in dealing with family issues. Mr Cooper said, but the US is even less so because there is more worry about legal liability.

The Canadian philosophy about family assistance is that service is available outside of the EAP. In the US, he said, the concern is that " 'anything we do, we must look over our shoulders and see who is going to sue us.' "

The treatment of choice is different in the two countries as well. In Canada, not many EAPs deliver services because, generally, a wide range of community services is provided by the government. In the US, more EAPs provide treatment.

New drugs: the suggestion of dependence prevention

(from page 1)

Benzodiazepines are currently the drugs of choice, having a high benefit/risk ratio. The "benzodiazepine loading-dose technique" in which unit doses of diazepam are given at appropriate intervals, titrating the amount given against the patient's reaction, has greatly simplified AWS treatment.

In this way, the drug can be stopped when the patient shows signs of improvement.

Dr Naranjo said there is no evidence supporting long-term use of benzodiazepines after withdrawal symptoms are controlled, yet these drugs are being improperly prescribed; they are detected in 33% of alcoholics undergoing medical assessments. When properly applied, this loading-dose technique does not result in dependence.

Calcium blocking cardiovascular drugs are also being investigated in AWS treatment. One of these, nifedipine, reduces AWS in rats and delays acquisition of tolerance. Testing in humans, however, may depend on developing calcium blockers that affect the central nervous system without exerting cardiovascular effects.

"The value of these observations is not necessarily from the point of view of therapy but because they suggest we can manipulate the acquisition of tolerance. Tolerance and dependence go hand in hand. It would mean that for the first time we have drugs that can prevent becoming dependent on alcohol," Dr Naranjo told **The Journal**.

Agents currently used to reduce alcohol consumption are of questionable efficacy and possess substantial toxicity and a potential for harmful drug interactions. Dr Naranjo said this arose because disulfiram was introduced 40 years ago and became an established treatment before it was rigorously tested. Studies between 1948 and 1980 failed to produce scientific evidence supporting the efficacy of any alcohol-sensitizing drugs.

Research to identify and test new drugs for decreasing ethanol intake has shown that serotonin uptake inhibitors have been effective in reducing the number of drinks consumed and increasing the number of abstinent days.

However, several researchers have expressed concern that reliance on drugs might be deleterious unless combined with behavioral training or other treatment.

Drugs to attenuate alcoholic chronic organic brain syndrome (COBS) are "conspicuously absent," Dr Naranjo said, making noteworthy recent reports that fluvoxamine, a serotonin uptake inhibitor, improved memory in a study of 10 alcoholics. Alcoholic COBS results in serious psychosocial dysfunction in about 10% of alcoholics, impaired brain function in between 50% and 70%.

NEWS

Intervention is worthwhile, cost-effective

COAs do work of three — but tend to burn out

By Karin Maltby

SEATTLE — Adult children of alcoholics (COAs) are valuable employees because they haven't learned how to say 'no,' and will do the work of three for the salary of one. But, at the same time, their outstanding work performance is short-lived because COAs "burn themselves out within five years."

This is the view of Janet Woititz, EdD, president, Institute for Counseling and Training, Verona, New Jersey, and author of several books about COAs.

COAs are prime candidates for burn-out because, regardless of their achievements at work, "they don't feel good about themselves and don't believe they've earned recognition," she told the North American Congress on Employee Assistance Programs here.

Without intervention and assistance, COAs in the workplace will "get sick, regroup, and head for the next burn-out." But, because they are such good employees, intervention is worthwhile and cost-effective.

Dr Woititz said COA employees carry subconscious messages from childhood, myths they developed in reaction to living with chemically dependent parents. For example: a young COA feels guilty about her inability to stop parental drug abuse; as a respected employee, she again experiences guilt if she is unable to complete tasks not within her experience or job description.

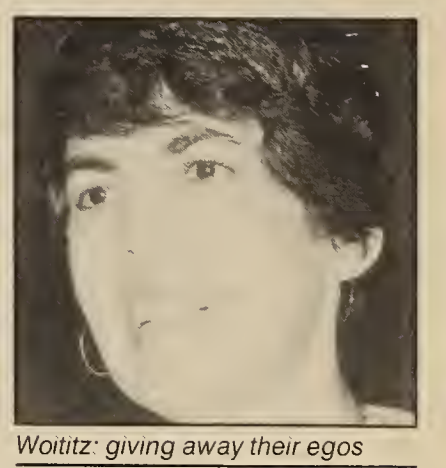
Golobitsh

COA employees: getting sick, regrouping, heading for the next burnout

A COA employee — at whatever level in a company — considers himself worthless if not busy, at fault if something goes wrong, and fearful of discovery by peers: 'I'm a fraud. Others will find out I'm not creative, brilliant, not capable of doing my job because in my family the disease of alcoholism was my fault.'

COAs at the management level "give away their egos to the organization. If the organization does well, they're fine; if the organization is doing badly, somatic symptoms appear," Dr Woititz said.

Typically, COAs as supervisors want to make immediate changes although years of organizational turmoil may have preceded them, want to be liked by peers and subordinates at whatever cost to themselves, and consider themselves bad managers when employees fail.



Woititz: giving away their egos

COAs know "how to behave at work because they feel comfortable; but leaving work is tricky because they have to be themselves," said Dr Woititz.

Anti-sniff coalition disbands

By Maureen Brosnahan

WINNIPEG — Winnipeg's up-again, down-again Anti-Sniff Coalition has once again ceased operation.

Chairman Jack Eyre says lack of commitment by other agencies and a sense of frustration among coalition members led to the latest demise. It's the third time in the past decade the coalition has folded.

Mr Eyre said part of the problem was that the coalition had no mandate to undertake its work, and other groups, such as schools and child welfare agencies, were unable or unwilling to commit funds and develop programs to deal with the issue of solvent abuse.

"Unless there's a collective effort on their part, I think this will continue to be a problem," he said. "It requires a multi-disciplinary approach, and right now that's not really happening. It's a hit and miss affair."

The coalition was first established in the mid-1970s to heighten awareness of solvent abuse in Winnipeg and to search for solutions to curb the problem.

In 1979, the coalition successfully lobbied for a city bylaw to restrict sale of solvents to young people. The bylaw was struck down three years later when a court ruled it was beyond the city's jurisdiction.

Helgason: filling the void

Mr Eyre says although the coalition, made up of about a dozen active members working in the inner city, has folded, he believes it did make headway. "There's a greater willingness at least to acknowledge the problem."

As well, the coalition established a comprehensive library on solvent abuse for the public and set up support groups for young sniffers.

Solvent abuse is seen as a serious problem in Winnipeg and, in recent years, has been linked to juvenile prostitution. Several people have been charged after youths were enticed into trading sexual favors for solvents (**The Journal**, August, 1986).

Wayne Helgason, a Winnipeg child care worker who works with young sniffers, says some groups are coming forward to fill the void left by the coalition. Support groups for young sniffers are continuing, and the solvent-abuse library has been taken over by a community advocacy group.

Teen children of alcoholics finding Toc Alpha helpful

TORONTO — Opportunities for support and involvement offered by a Canadian youth organization are proving helpful for teenage children of alcoholics (COAs).

Toc Alpha, an acronym for Taking On Concerns About Life, People, and Human Achievement, is the youth wing of Alcohol and Drug Concerns, Inc (ADC).

Founded in 1956, Toc Alpha sets three primary objectives for its 14-to-24-year-old membership:

- to provide attractive options to alcohol and other drug use,
- to encourage good decision-making skills in an environment of positive peer pressure; and,
- to increase awareness of the psychological, social, physiological, and legal implications of alcohol and other drug use.

Karl Burden, ADC executive director, describes Toc Alpha as "aptly suited for children of alcoholics since they can learn about substance abuse, receive emotional support from peers, yet not disclose their family problems."

COAs are often reluctant to use clinical facilities and reject programs that identify them as troubled, says Mr Burden.

"For many young people, Toc Alpha has provided a vehicle through which they have come to realize their home problems are not unique, and then the organization has helped them learn effective coping strategies."

AIDS tests now mandatory for Soviet citizens, visitors

MOSCOW — Mandatory testing for the HIV virus has been instituted by the Russian government for its own citizens and foreigners from countries with a number of AIDS cases.

A Soviet citizen who puts another at risk of being infected faces a five-year jail term and an eight-year term if another person is deliberately infected. Foreigners found to have the HIV virus will be deported.

A report from the Novosti Press Agency said only 102 cases of HIV infection have been found among a million people so far tested. Centres where people can be tested anonymously have been established around the country.

Mikhail Narkevich, Ministry of Public Health, said: "We find it is necessary to examine all Soviet citizens who return home from countries where AIDS epidemics are recorded."

World drug law hits death-penalty snag

'We do not see why mass murderers should not be punished:' Malaysia

By Gamini Seneviratne

VIENNA — Capital punishment for some drug offences is expected to re-emerge as an issue at this month's meeting here of the committee drafting the new United Nations convention on illicit drug traffic.

The convention is aimed at removing the profits from illicit traffic in narcotic and psychotropic drugs (The Journal, April).

The question is whether, for the convention, the death penalty should be globally endorsed as a possible sanction against serious drug crimes. It arose at the July meeting of the drafting committee in a bitter clash between Malaysia and the Nordic countries.

Malaysia, alone so far, wants the penalty in, allowing that application would depend on "the nature and gravity of the offence" and be subject to each country's "constitutional limitations, legal system, and domestic law."

The Nordics counter that the death penalty is a "cruel, inhuman, and degrading punishment with questionable deterrent effect" and that the UN is for its abolition.

The Soviet Union and Indonesia were prominent in fashioning a compromise at the July meeting; it recognizes both the moral objections to capital punishment and its possible deterrence value. (Canada and the United States stayed conspicuously aloof from debate.)

However, while observers concede that explicit mention of capital punishment is unlikely to survive in the convention because it is abhorrent to too many, they also note that with so many countries in the grey area of the 'don't knows,' the issue is unlikely to be resolved easily.

Malaysia's advocacy for the death penalty rests only partly on its deterrence value. Prime Minister Mahathir Bin Mohamad tends to stress the morality of it. As president of the recent world drug conference here (The Journal, August), he said: "We still have kept the punishment (death) for crimes like murder, and we don't see why mass murderers like drug traffickers should not be (similarly) punished."

He said that while "governments . . . that do not have the death penalty and are under pressure not to . . . cannot very well support the law in our countries," countries where it does exist should extend it to cover serious drug offences.

US Deputy Secretary of State John C. Whitehead, asked the question directly at the same conference, declined to say more than "it is something for us all to consider."

Said Francisco Ramos Galino, new director of the UN Division of Narcotic Drugs, earlier this year: "We will take time drafting the convention, because we need one which many countries will ratify fairly early."

With the efficacy of capital punishment unproven, and with several countries implacably opposed, its inclusion even obliquely would be likely to defeat this end.

NEWS

RESEARCH UPDATE

Clonidine scores well for alcohol withdrawal

Clonidine appears to be as effective as a benzodiazepine in the management of acute alcohol withdrawal. In the first reported comparison of the two types of drugs, a physician and a pharmacist from the University of South Carolina, Columbia conducted a double-blind, randomized trial with 61 male alcoholics admitted to a local inpatient alcohol detoxification unit. The subjects randomly received clonidine or chlordiazepoxide over a 60-hour treatment period. Gregory Baumgarter, MD, and Randall Rowen, PharmD, found clonidine was more effective than the benzodiazepine in reducing alcohol withdrawal, systolic blood pressure, and heart rate over the entire study period. They said it was so effective in dropping blood pressure in the first 12 hours of therapy that it could preclude using an additional drug to combat the hypertension frequently seen in acute alcohol withdrawal. In addition, clonidine was as good as chlordiazepoxide in improving scores on a number of tests to measure psychological features of withdrawal. Adverse drug reactions in both groups were similar, although those taking clonidine reported less nausea and vomiting. The researchers conclude clonidine, an alpha-2 agonist with no dependence liability, should be "seriously considered" as an alternative form of pharmacotherapy for acute alcohol withdrawal syndrome.

Archives of Internal Medicine, July, 1987, v.147:1223-1226.

Cig ads reaching children

Even young children are very aware of cigarette advertising, a study of a group of Scottish children between ages six and 17 years suggests. The University of Strathclyde study involved interviews in June/July, 1985 with 726 Glasgow children asked a variety of questions about nine glossy print advertisements for cigarettes, all but one of which had appeared in magazines during 1985. While the proportion of subjects who said they had seen the ads increased with increasing age, a majority at primary school level said they could identify the ads from the "long-running, highly prominent campaigns," which did not change much from month to month. Even young children were able to identify brand imagery in the absence of brand names. For example, 40% of eight and nine year olds and 72% of the 10 and 11 year olds were able to identify the Marlboro advertisements. As for brand personalities, the researchers said the older children had quite an adult understanding of the types of lifestyles the ads were attempting to project; even many of the older primary school children had a rudimentary awareness. While results did not necessarily indicate advertising induces children to start smoking, advertisements are getting through to children, and particularly to underage smokers, the marketing and psychology department researchers conclude.

British Journal of Addictions, June, 1987, v.82:615-622.

IV methamphetamine/lead poison link

The possibility of acute lead poisoning from the intravenous (IV) use of illicit methamphetamine is raised by three Oregon researchers from an area where large quantities of the drug are manufactured. They report two cases of patients who presented to hospital with nausea, vomiting, weakness, and weight loss following IV use of methamphetamine. Both patients had abnormal liver function, low hematocrit values, and elevated blood-lead levels. Analysis of the drug used by one patient showed 889 parts per million of lead. The 28-year-old man was estimated to have injected about 0.1 milligrams of lead directly into his bloodstream; his initial blood-lead level was more than three times the normal. In the other case, methamphetamine was also considered the only possible source of lead poisoning, with improper synthesis and purification of the illegal drug considered responsible. Both patients recovered after treatment but required outpatient treatment; one was hospitalized twice. Both excreted large amounts of lead in their urine after treatment with edetic acid. The researchers note that the usual laboratory tests for lead poisoning could be misleading in these acute cases, and diagnosis could be difficult because of the variable and nonspecific signs and symptoms.

The Journal of the American Medical Association, July 24/31, 1987, v.258:510-511.

New heavy-drinking marker

A new marker has been hailed as the most reliable laboratory indicator of heavy drinking to date by five Australian researchers from the department of medicine, University of Queensland, Royal Brisbane Hospital, Brisbane. The group tested desialylated transferrin in blood samples from a group of 20 male alcoholics and from a number of healthy subjects and patients with non-alcohol-related disease, including liver disease, that is morphologically indistinguishable from alcoholic hepatitis. When the desialylated transferrin was measured as a percentage of total transferrin in the serum of the test subjects, the mean values were significantly higher for the alcoholics than the mean for all the other groups. Since none of the non-alcoholic subjects had a value above 1.5%, this was taken as a cutoff point; 18 of the 20 alcoholic subjects (90%) had values above 1.5%. The researchers say this shows desialylated transferrin is a very specific indicator of heavy alcohol consumption because no false positive scores were found in any of the controls. They also say the method compares favorably with other routine blood tests of chronic alcohol consumption. For example, gamma-glutamyl transferase estimations are most widely used, although they have a sensitivity of between only 30% and 80%. In this study population, gamma-glutamyl transferase values were significantly raised in only 35% of the 20 alcoholic patients.

The Lancet, June 6, 1987, v. 8545:1292-1294.

Pat Rich

Goldbitsh

Abusing: for the victim, sometimes it's a broken heart, not a broken leg

Drink can worsen violence, doesn't cause it: counsellor

By Betty Lou Lee

HAMILTON — Alcohol and violence are linked so often that there's a general belief they are cause and effect.

Robert Murray, a counsellor with the Waterloo regional alcohol and drug assessment service of Ontario's Addiction Research Foundation, adamantly denies this.

"Alcoholism doesn't cause violence. There is no evidence whatsoever that it does. Some assume that because there's an 80% association with alcohol and abuse, it must cause it. That's not necessarily so."

For his audience of addictions workers at the annual Institute on Addiction Studies, held here by Alcohol and Drug Concerns, Inc, the concept wasn't easily accepted.

Interaction

Mr Murray agreed abusing both alcohol and your wife can interact and exacerbate each other. The two may have common background factors — a family history of alcoholism and abuse, for example.

Yet, not all alcoholics are abusive, and all abusers aren't alcoholics (The Journal, November, 1986). Some alcoholics are abusive when they're not drinking and continue to be abusive if they quit drinking.

Mr Murray will not accept a man into his treatment program for spouse batterers until he is under treatment for any alcohol or other drug problem he may have.

Subtle abuse

"He has the idea he'll go for alcoholism treatment and that will fix the problem. I'd be happy if it worked, but it doesn't. He may stop drinking, the cops are not called, and she doesn't have any bruises. But, the subtler abuse continues.

"His control of his wife becomes subtler, he becomes better at it; but, the basic dynamics won't change."

Mr Murray describes a four-stage battering cycle in which tension leads to violence because the man has never developed any other way to deal with it. Then, there's guilt, remorse, and shame, followed by a "honeymoon" period. As the cycle intensifies, the guilt is reduced and the honeymoon period gets shorter.

Mr Murray makes no distinction between verbal and physical abuse: "I don't put it on a scale. It's hard to forget if you've been called a whore by your husband. It's not a broken leg, but a broken heart. A broken leg heals.

"If he's physically abusive, he's always also verbally abusive. If he's verbally abusive, he may not be physically, but there's a tendency for the violence to escalate."

Although violence is the only way abusers have of responding to the anger that tension creates, they are not usually violent outside the home, he noted.

Any woman in an abusive situation should leave, or threaten to, Mr Murray said. But, societal attitudes and actions often make this difficult.

Police reluctant

Belief that a man's home is his castle, or that one shouldn't interfere in a marriage, is still common. Police have been reluctant to lay charges; affordable day care or housing are scarce.

"Rambo touched a chord that equated masculine power and force, (that gave) validity to physical force and intimidation. There are a lot of little Rambos out there."

The woman is also caught in a bind: "If she leaves, she's a deserter; if she stays, she needs or likes the abuse," Mr Murray said.

In wake of the Archibald report

Bermuda program building

HAMILTON, Bermuda — The first-year report of the National Alcohol and Drug Agency (NADA) here shows it has acted, in some way, on 59 of 65 recommendations of the Royal Commission into the Use and Misuse of Illicit Drugs and Alcohol.

The NADA, a coordinating agency, was established by Bermuda Premier John Swan to "implement the important initiatives" highlighted in the final report of Commissioner H. David Archibald (**The Journal**, August, 1985).

Action taken by NADA includes an island-wide resource inventory, a second survey of drug use by students, establishment of a youth-to-youth service concentrating on development of student leaders, alcohol and other drug education programs in schools, training sessions for teachers.

A PRIDE-Bermuda (Parent Resource Institute for Drug Education), as well as a community-based, employee assistance program have also been established.

Working with several government ministries and volunteer organizations, the NADA has also begun addressing other issues.

Legislation is being drafted to increase penalties for importing and trafficking and to seize the proceeds of drug crimes.

Education programs are being developed for the public, police, parents, and teachers.

Enhanced treatment and rehabilitation programs under study include expanding alcoholism services through day care and outpatient facilities.

The NADA has also worked with Bermuda's Ministry of Health and Social Services and several concerned organizations to propose amendments to the Liquor Licence Act.

Mr Archibald told **The Journal** he was more than satisfied with the progress the authorities were making in implementing his recommendations.

"It's unusual for any Royal Commission report prepared in the British Commonwealth to have any significant impact on anything. Bermuda is an outstanding exception to this."

On-site wellness programs key to good management

By Karin Maltby

SEATTLE — Health care's escalating costs combined with a shrinking workforce in North America will hasten the trend to on-site wellness programs for employees.

And, for each dollar invested in health promotion, more revenue will be earned back, an expert on corporate health management told the North American Congress on Employee Assistance Programs (EAPs) here.

Larry Chapman, former senior health promotion and wellness staff specialist with the United States Public Health Service, said EAPs should encourage the concept of wellness programs as an essential component of management.

Further, EAPs are in a critical position to change the wellness of workers by encouraging them to look at and modify their lifestyles through company wellness programs.

He defined wellness as "an intentional choice of lifestyle characterized by balance, personal responsibility, and maximum enhancement of physical, mental, and spiritual health." He said too much emphasis is placed currently on only physical health by EAPs and by management.

For example, he said, of 100 workers in the US, 80 believe they are in good health. However, 30 of the 100 are smokers, 27 have hypertension, 18 are more than 20% overweight, 64 get no regular exercise, 13 drink more than three ounces of liquor daily, 43 are under severe stress, 11 would like to talk to a counsellor, and 63 don't use the health-care system appropriately.

And, 91 of the 100 people have "very little incentive to change their behaviors."

Corporate managers must recognize that since some workers are more resistant than others to better health, programs may be limited to, for example, urging procrastinating "resisters" finally to quit smoking and encouraging "stalwart," three-pack-a-day smokers at least to consider quitting.

Broad brush

While many EAP programs have dealt primarily with chemically dependent employees, a move to a "broad-brush" approach that covers any factor reducing work performance can enhance a preventive wellness program.

Mr Chapman outlined a typical program model:

- awareness communication — to inform and educate employees about the wellness program 'market' that exists in their place of work;
- health management — to promote individual behavior change via a process of voluntary health and fitness testing;
- group intervention — for example, stop-smoking groups; and
- supportive environment — for example, physical fitness apparatus available for use by employees.

He warned it may take an employee from 18 months to three years to change an inappropriate behavior.

The average cost, he estimated, would be about $35 to $70 a year per person to "create a good wellness program."

Linkages

He said linkages between EAPs and health promotion programs include joint committee membership, identifying referral opportunities, providing literature to employees on each program's mandate, combining supervisory training, actively promoting each other, highlighting mutual confidentiality, cross-consulting, and locating both programs in the same unit of the company.

Mr Chapman predicts the time will soon come when programs will address AIDS as a prevention issue. And, workers with a genetic predisposition to other chronic, life-threatening diseases may volunteer for "gene profiling" through a simple blood test.

"We will be able to tell employees what (disease) they may get and put them on a prevention program."

Shrinking workforce: for each dollar invested, more will be earned back

'Important information on immunogenicity, safety'

Canadians at front line of AIDS vaccine work

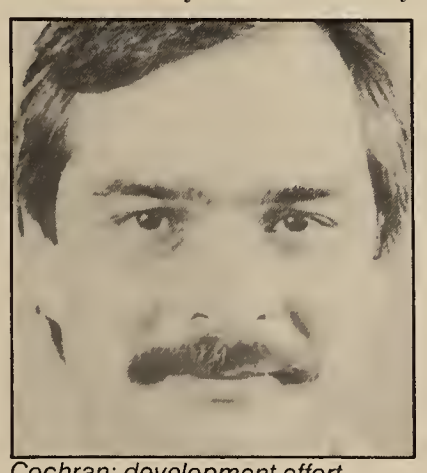
By Kate Fournis

TORONTO — The AIDS vaccine approved for clinical trials by the United States Food and Drug Administration (FDA) recently was largely developed and tested by Canadian researchers — a fact one researcher believes will put Canada in the forefront of AIDS research.

The vaccine, developed by MicroGeneSys Inc, West Haven, Connecticut is the first to be approved for human testing in the US.

Although it is a US company, the co-director of the vaccine development effort is Canadian Mark Cochran, PhD, director of molecular genetics.

Animal studies for immunogenicity and safety (specifically in rhesus monkeys) were done by



Cochran: development effort

Peter Gill, PhD, director of the bureau of microbiology in the Laboratory Centre for Disease Control in Ottawa.

Commenting on the significance of the Canadian role in the approval of the vaccine, MicroGeneSys president Frank Volvovitz told **The Journal**: "Our belief is that it was the largest primate trial that has been conducted with any kind of AIDS vaccine. It provided very important information on immunogenicity and safety."

Dr Gill said if the vaccine is approved for testing in Canada, "it will make us equal to other countries and will really keep us in the forefront of AIDS research.

"It will give Canada a niche in HIV (human immunodeficiency virus) vaccine trials."

The FDA approved the vaccine for Phase I study, to see whether the vaccine induces an immune response in humans.

The company has also applied to the Canadian government for approval to do a separate Phase I study of the vaccine, Mr Volvovitz said.

Phase III study — to see whether the vaccine actually protects people from becoming infected with HIV — is at least 18 months away, he added.

The vaccine uses a recombinant HIV protein reproduced in insect cells.

The protein is then purified and formulated into a vaccine preparation.

Viral proteins produced in insect cells — specifically, a cell line from army worms — are more like the natural virus surface than those produced in bacteria, Dr Gill explained. Theoretically, the more natural vaccine might produce a better response.

When Dr Gill tested the vaccine in rhesus monkeys, they showed a good immune response with no adverse effects.

"The monkey finds it a very potent immunogen which stimulates a very good antibody response."

The antibodies were found to be neutralizing antibodies that could inactivate HIV in vitro.

The rhesus monkey evaluations in Ottawa brought research on the vaccine to the point of approval by the FDA, Mr Volvovitz said.

The controlled Phase I trial will be of 80 volunteers, primarily homosexual men at low risk of HIV infection, and is expected to run for about six months.

Clifford Lane, MD, deputy clinical director of the US National Institute of Allergy and Infectious Diseases, will direct the study.

Austrian vaccine goes to human trials in 1988

By Gamini Seneviratne

VIENNA — An Austrian drug company has developed a first-generation, prototype AIDS vaccine which could be ready for human trials early in 1988.

Two chimpanzees have already been inoculated, and immunization is being systematically increased.

The immunity level at which the chimps will be infected with the AIDS virus, to determine the protective effectiveness of the vaccine, is expected to be reached soon.

Robert Gallo, MD, United States Institutes of Health, was ready to endorse the Austrian company, Immuno AG, "because it's the first group to stick its neck out to develop an AIDS vaccine, it has proven expertise, and it has experience using chimps — a prerequisite because it's the only animal that can be routinely infected."

The prototype vaccine has been developed from the whole protein envelope of the AIDS virus, rather than parts of it, Johann Eibl, research director, told **The Journal**.

The company, is the first in the world biogenetically to manufacture the antigen on a kilogram scale.

Campus program: making moderate drinking the norm

TORONTO — A campus program to educate students about responsible drinking may help promote universities as places where moderate, appropriate alcohol consumption becomes the norm.

Campus Alcohol Policies and Education (CAPE) is a health promotion program directed primarily at first-year students. The two-pronged program, tested at the University of Western Ontario in 1984, involves disseminating information about appropriate and inappropriate alcohol use, as well as specific intervention strategies to be used by university taverns and administration, including reduced prices for low-alcohol beer.

In an evaluation of the program, researchers found most students were aware of the CAPE program, and most, even though they frequented university taverns, endorsed the program and its prescriptions for low-risk drinking:

1. No more than one drink per hour, no more than four drinks per occasion;
2. Seven drinks or fewer per week;
3. If driving, don't drink; and
4. When studying, don't drink.

Of those students surveyed, 94% deemed the program a good idea.

The report notes researchers were encouraged to find that a program focusing on the behavior of students "was almost universally endorsed by students.

"Not only did students seem to approve of the program as a whole, but they even endorsed the prescriptions for appropriate drinking. Typically, such prescriptions are met with derision, and it is to the program's credit that students endorsed these concepts. . . .

"It is anticipated that as all years of the university are exposed to CAPE (this year's first-year students are next year's second-year class, and so on), the university itself will become a milieu in which students reinforce each other and appropriate, moderate consumption of alcohol becomes the norm."

The CAPE program development and follow-up evaluation were conducted by Louis Gliksman, David Hart, and Robert Simpson of the Addiction Research Foundation, and Thomas Siess, director of student services, University of Western Ontario.

LETTERS

'Free speech' for tobacco ads is a red herring, says reader

In **The Journal** (August) Richard Gilbert repeats his claim that legal restrictions on cigarette advertising are a dangerous infringement on freedom of speech. Unfortunately, I missed his original article on the subject (January, February), reading only some of the rather abusive replies. It is, however, very difficult to understand how someone of Dr Gilbert's intellectual achievements can miss what appears to be the line of reasoning supporting an ad ban.

Either he accepts that such ads have a significant effect on children and teenagers to encourage them to smoke, or he does not.

If the latter, it is hard to see how he can expect to be taken seriously. Something beyond peer pressure or parental example must be present to lead young people to take up an activity which is not cheap, has no apparent pleasure attached to it, and is known to cause a horrifying level of disease.

Brand loyalty among smokers is strong: what, therefore, could cause the tobacco companies to spend money on advertising and sponsorship, if not to create new users?

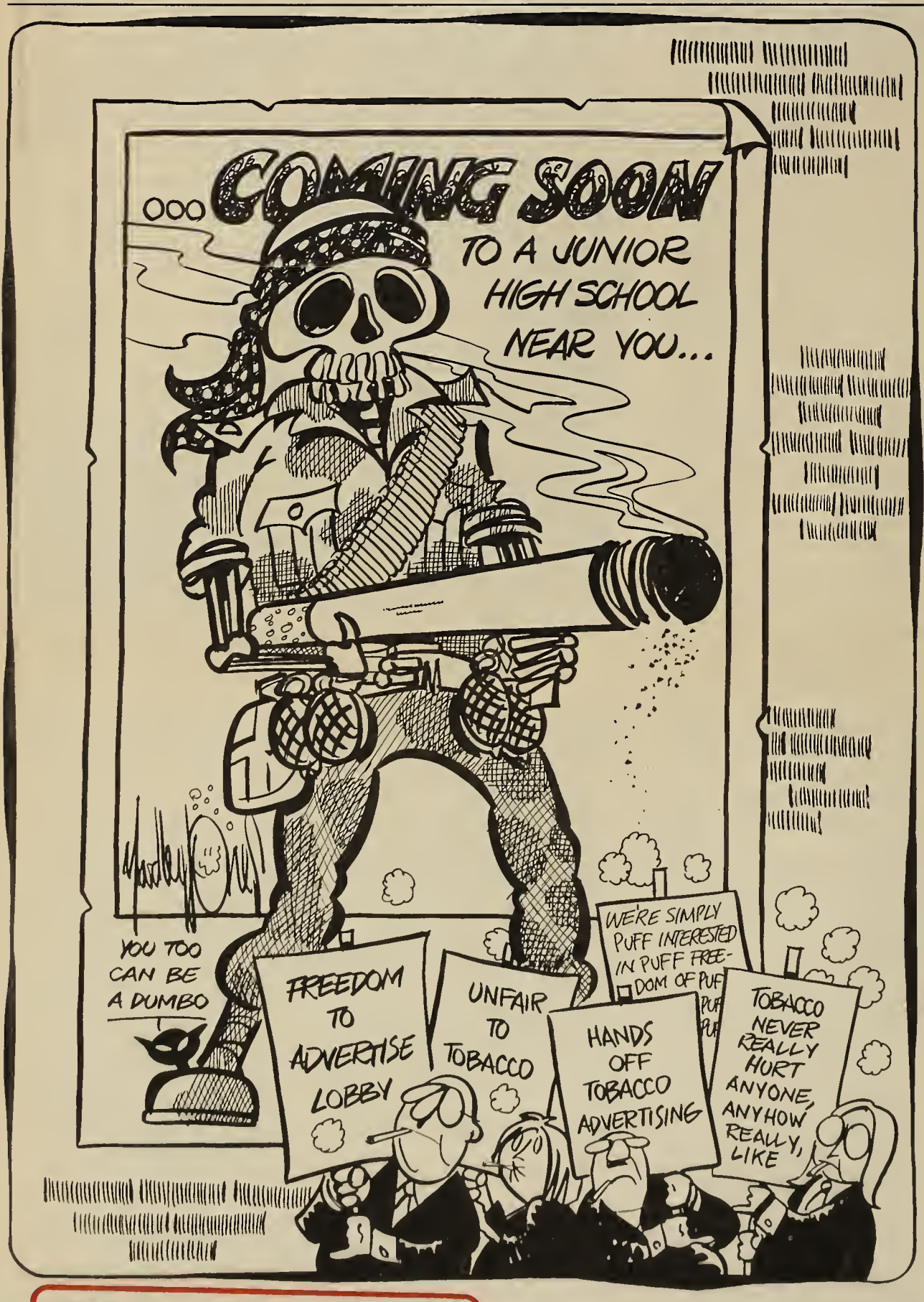
A secondary, but similar, premise lies in the effect of advertising in weakening the resolve of those already addicted to break free.

If Dr Gilbert does accept that ads for cigarettes aim to make smoking look healthy, respectable, and liberating to minors and existing addicts, arguments based on freedom of speech are irrelevant. The intended audience is not free to respond to the message in a rational way. A 14 or 15 year old is too young to vote, too young to be allowed to buy alcohol, too young to leave school or home; she or he cannot clearly form ideas of harm years into the future, or comprehend the nature of addiction.

The value of free speech lies precisely in its potential to influence an audience which is itself free to assess the message conveyed. The audience may be unwise, stupid, ignorant, or perverse in its response, but it must be rational. If its response is purely and always of a kind with those of speechless creatures to natural or artificial stimuli, the speaker may be free. But, what he says and his freedom to say it lose all their value.

References to "free speech" are a red herring when restrictions on tobacco advertising are being discussed. To an industry threatened with the loss of huge profits and devoid of genuine arguments, such a line of counterattack is likely to appeal. It is, however, particularly sensitive when someone of Dr Gilbert's credentials takes up a position which corresponds to a part of the public stance adopted by the tobacco companies.

Philip Webb
Toronto, Ontario



More evidence required

Stan Sadava's homily on the need for tolerance and his apparent distaste for *ad hominem* attacks (June) just doesn't square with his dismissal of the Non-Smokers' Rights Association (NSRA) — perhaps the strongest force for preventive medicine in Canada — as "moral entrepreneurs."

Dr Sadava's charge that the NSRA "would like to drive tobacco completely underground" is misinformed. My understanding is that the NSRA has consistently opposed a ban on the sale of cigarettes and, in fact, continues to take the position that a ban would be irresponsible in Canada.

Apart from Dr Sadava's defence, however, Richard Gilbert's original problem (January, February) still remains: how to explain the annual expenditure of over $2 billion (US) by hard-nosed, transnational tobacco conglomerates for advertising and promotion of tobacco products in a shrinking North American market?

When this type of extraordinary expenditure is used to market illegally a 'legal,' inherently dangerous, addictive product through calculated deception, a great deal more hard evidence will be required from Dr Gilbert before we believe the Tobacco's Institute's claim that tobacco manufacturers aren't trying to hook our kids.

Ronald M. Hart
Executive director
Relatives of Dead and Dying Smokers (RODDS)
Picton, Ontario

Teens' erratic behavior may not be drug induced

Rural drug education support groups such as the one based in Northbrook, Ontario (**The Journal**, August) would find the Britnell Book Shop telephone service for book orders useful since many do not have quick access to a bookstore (1-800-387-1417).

Another suggestion for fellow educators is not to focus attention exclusively on drugs and alcohol. Other ills may be overlooked if deviant behavior in teenagers is first ascribed to drug addiction. Indeed, professionals on our psychiatric wards find it difficult to distinguish between the symptoms of schizophrenia and drug addiction when a patient is first admitted. As one young schizophrenic recently stated to me: "They thought I was on drugs, but after a week in the hospital, the hallucinations did not go away."

Parents who practise 'tough love' and throw their sullen, detached teenager out may unknowingly be putting a very ill individual on the street. Diagnosis of a teenager as a drug addict or alcoholic may be too quickly made by teachers in the school staffroom. Our eagerness to embrace drugs or alcohol as causes for weird behavior is a symptom of society's reluctance to learn about severe mental illness such as schizophrenia.

Dan Webster
High school teacher
Wingham, Ontario

(Ed note: Mr Webster is a co-chairman of a support group for parents of schizophrenics.)

Correction

The September issue of **The Journal** identified pentazocine (ie, Talwin) as a non-narcotic prescription analgesic. Although not derived from opium, pentazocine is listed as a narcotic under Canada's Narcotic Control Act.

The Journal

A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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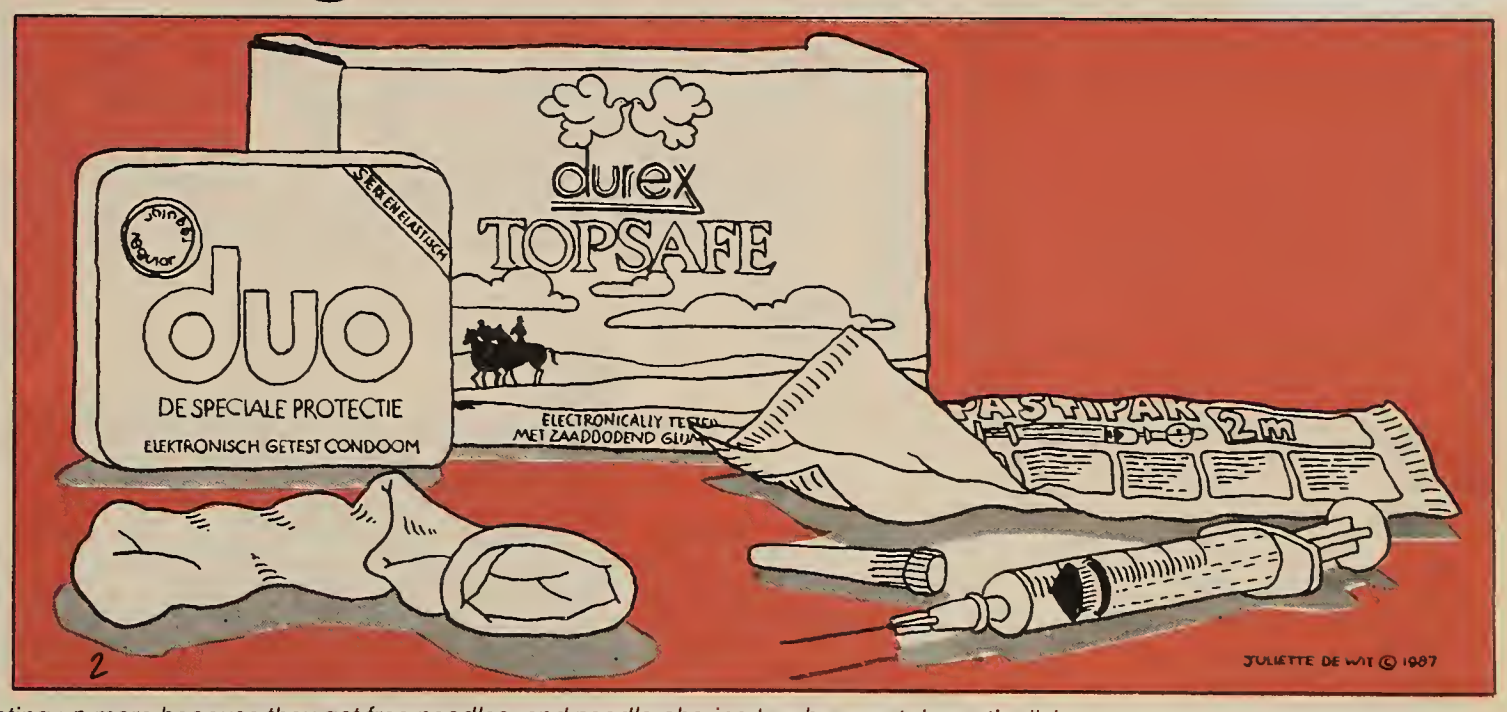
Dutch target IV drug users to contain HIV



Brussel, brochure illustration: 'we did not find people shooting up more because they get free needles, and needle-sharing has been cut dramatically'

In Amsterdam:

The greatest threat of the spread of AIDS in society in North America and Western Europe is via intravenous drug users and prostitutes. The most effective prevention efforts are an end to needle sharing, use of condoms, and more methadone maintenance programs. But, while the politicians in North America procrastinate, agonize, or avoid the issues, and many drug experts debate them, a number of countries in Western Europe have moved ahead with vigorous prevention programs.

Leading is the Amsterdam Municipal Health Service. The Dutch have a reputation for clear-headed, pragmatic, and business-like approaches, and its programs are just that. The aim is to contain, as far as possible, and with every means possible, spread of the HIV virus. Contributing editor Harvey McConnell, in the first of a series of reports, talks to Giel Brussel, medical director of the service's drug program, and Krishna Kanhai, medical director of one of the city's suburban clinics.

Amsterdam's Municipal Health Service will distribute 700,000 free needles and syringes this year among 8,000 heroin users as part of its concerted effort to contain the spread of the HIV virus

"It is rational, but it is not a miracle," is the pragmatic view of Giel Brussel, medical director of the drug abuse program. "We doubt it will be totally efficacious in prevention, it's slow."

It is too early to find if the needle exchange program has slowed the spread of the HIV virus. However, it is clear, after a year, that provision of free needles does not entice people into IV drug use and it has dramatically cut the rate of needle-sharing among addicts.

■

The needle exchange program is allied with a free methadone maintenance program and unceasing education and prevention efforts among drug users, and their sexual partners, and professional prostitutes, their clients, and their pimps. Even the streets are scoured for dirty needles.

Amsterdam's heroin user population includes some 2,000 from the former colony of Surinam, and a floating population of about 1,500 foreigners. About 60% "chase the dragon" (smoke heroin), and most users combine it with cocaine, alcohol, and tranquillizers when available.

"Amsterdam is only a small city, about 400,000 in the centre, so our percentage of heroin users is on an American (United States) level," Dr Brussel points out. "Fortunately, the heroin user population is older (median age 30 years), and there are few young users."

■

Dr Brussel says that "at the moment our infection rate is fairly comparable with the international situation, but you have to bear in mind that our needle exchange program has only really existed just over a year." It could be some time before the constant research on every aspect of their programs shows any slowing of HIV transmission.

On the other hand, there is no evidence that providing free needles and syringes has either created new heroin users or changed the pattern of use among those already involved.

"At the start, we did wonder if the people would begin to shoot up instead of chasing the dragon," Dr Brussel adds, "but we have found people do not change their drug use behavior because of this system.

"We do not find people shooting up more because they have access to free needles."

A study of IV users shows, how-

(See Harm, page 8)

Draper on public health

COPENHAGEN — Many West European governments are confronting the AIDS threat among both the general public and intravenous drug users with a vigor still lacking in North America, even though the threat in Europe is not as great at the moment.

Ron Draper, Health and Welfare Canada and currently with the European office here of the World Health Organization, believes the issue is being addressed in Western Europe with "clearer public health considerations than in North America." (Mr Draper is director-general, Health Promotion Directorate.)

Attitudes can vary between the extremely repressive, as in the Soviet Union (see page 3), to the extremely liberal, as in Denmark and the Netherlands.

However, Mr Draper points out that while the problem of AIDS in North America "gets mixed up with people's attitudes toward sex and homosexuality and what one is permitted to say in public, the Danes, for example, don't have that problem." He cites an advertisement here that depicts a condom stretched the length of a Copenhagen city bus. "You couldn't do that in Canada."

Lowell Leven, PhD, professor, public health, Yale University, New Haven, Connecticut, and a long-time WHO consultant, says: "There is a growing feeling in Western Europe that this is a problem which involves communal action rather than individual behavioral change. You can't approach what is happening (with AIDS) as you would a smoking-cessation program."

'We're thinking of 1990, we have no answers'

AMSTERDAM — Five years ago, Krishna Kanhai joined Amsterdam's health service and had straightforward concerns: "How to try to manage drug problems and how to do something for these people. Then AIDS has come along like a typhoon."

Typhoon AIDS has pushed Dr Kanhai into uncharted seas of drugs, sex, and death, and into a netherworld of prostitutes — male and female, pimps, brothel keepers, drug dealers, and even the prosaic tourist. And it has pushed him into preparing for the time ahead, when AIDS begins to strike down his drug-using patients.

Photos: Harvey McConnell
Graphics: Amsterdam Municipal Health Service brochure

At the end of the clinic day, following the usual conference — with his four social workers, two nurses, and two administrative staff — on every patient seen that day, Dr Kanhai makes it clear action is the only possible reaction to the drug abuse/AIDS problem.

"Deep in our hearts we hope they will find a drug for AIDS, but that is probably going to take 10 years. So we have begun to think about 1990, when people start going to ARC (AIDS-related complex) and then AIDS, and we don't have the answers yet.

"What shall we do? What shall our response be? How can we manage the problem? And what can we do now in order to be ready for that time?"

The aim at the moment is to develop special teams who will treat addicts with AIDS and train those close to them — mothers, wives, friends — in how to help them.

Dr Kanhai is adamant: "We don't want to isolate them. Absolutely. What we will probably do is make arrangements for them to get their methadone at home, so they don't have to come to our clinic."

Dr Kanhai is a native of Surinam who came to the Netherlands to study medicine and stayed after he qualified. He speaks Dutch, Hindi, English, and Spanish fluently and, one feels, can manage in several other languages as well.

His clinic has a large population of Surinam-born addicts. "The interesting thing about people from Surinam who get into drugs is that back home they didn't use anything, even cannabis. When they come to Holland, if they get into drugs, they go straight into heroin and cocaine. There is no 'stepping stone' progression for them."

Many of the immigrants have had trouble adjusting to living in the Netherlands; their education is poor, and most have blue collar jobs. Fortunately, there is no language barrier — Dutch is their mother tongue.

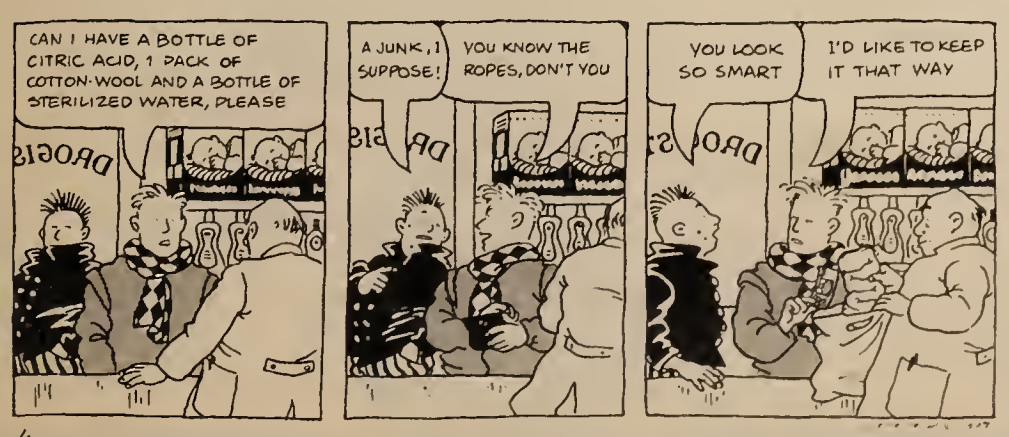
When patients first attend the clinic, Dr Kanhai tells them: "Look, we are going to try to help you. Our long-term aim is to cut off the drug, but at the moment you are not able to stop. So we will help you by giving methadone to try to regulate your use, and then you can stop."

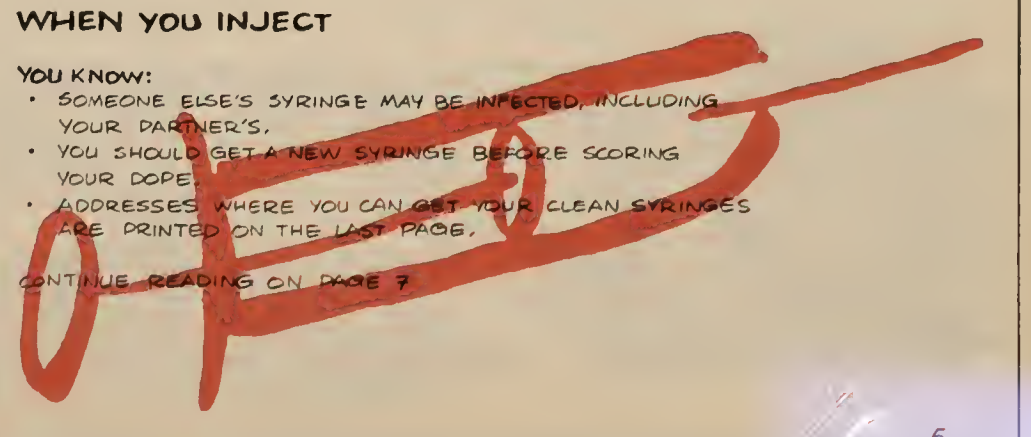
He is obviously compassionate and just as obviously not starry-eyed.

"We know most people are not going to give up, because they don't want to. Thus, the best thing we can do is maintain them on methadone."

Patients either get their methadone from buses which tour the

(See Couples, page 8)





Harm reduction

(from page 7)

ever, that provision of free needles has cut needle sharing to 15% from 70%, and most sharing now is with a sexual partner.

Most AIDS cases at the moment in the Netherlands are among the homosexual population — only 12 have been recorded among drug users — but voluntary testing has shown that at least 1,500 users are HIV-positive.

Dr Brussel, who has been with the service for 10 years, points out that a radical decision taken in 1979 to tackle a drug epidemic which burgeoned in Amsterdam in the early 1970s has enabled workers to move effectively with the arrival of AIDS.

Prior to 1979, Amsterdam tried conventional therapeutic communities, United States-style methadone programs, and programs which accepted drug use.

Dr Brussel: "None of these programs seemed to work out in the sense they reached only a small proportion and the results were deplorable. On the therapeutic side, only a small number kicked off, and, of these, you could ask the question whether even without any therapeutic involvement they would have become clean.

"On the other hand, social programs which accepted drug abuse had serious side-effects in the sense of public disorder, dealing, crime, and so on.

■

"In 1979, we started a policy we call 'harm reduction.' This means if you can't cure people, which would be preferable, maybe the best thing to do is to try to minimize the harm concerned with drug abuse, as well as the social problems.

"We started a methadone program which is aimed specifically at reaching the drug epidemic as a whole. We gave out methadone to people with a long history of addiction, who didn't want to stop, and who wanted to apply to a methadone program so they could, in a manner of speaking, lead less hazardous lives.

"I think it was a very important step because we reached the drug abusers as such. This means we have a medical model and a business-like approach. There is a fairly large amount of medical supervision as to their physical condition, as well as supplying them with methadone."

Addicts are given the freedom to choose a methadone level at which they can function well, although the maximum allowed — 60 milligrams a day — is lower than in some US programs. Those who have only been addicted a short time either get no methadone or a low dose for a short period.

■

Each day, buses tour the city either to give addicts oral methadone or to bring them to one of five clinics around the city. Again, pragmatically, workers give some addicts enough methadone for several days if there is a good reason why their daily attendance would be impractical. Doctors can also prescribe methadone for short periods.

The system has worked well, "and this is important because it has given us a good way to approach the AIDS problem."

Dr Brussel is blunt: "AIDS is an overriding disease. It is a threat to all IV drug users, and because of prostitution it is a threat to all of society. This means you have a big public stake in controlling or reaching an effective containment of drug use."

In late 1984, Dr Brussel's department started its first distribution of sterile needles in exchange for dirty needles. By the end of 1987, it will approach the million-a-year mark, which he considers is about the right figure.

"We apply the principle that AIDS is a problem with many side-effects. We think it is very important to keep the streets clean of used needles, because used needles can contain the AIDS virus and the virus can remain active for a few weeks."

Amsterdam: 'a big public stake in containment of drug use'

People are encouraged to scour the streets for used needles, as people scour the beaches for empty pop bottles, and some make a living by bringing in from 500 to 1,000 used needles in plastic bags. They are given sterile needles and syringes in exchange, "and they get whatever someone who is shooting up wants to give for it."

■

Amsterdam is a magnet for many drug users especially foreigners who use heroin.

One positive factor in Amsterdam is that the heroin-using population is older, and there are very few young Dutch people who now become involved with the drug.

"We don't see them, the police don't see them, the first-aid posts don't see them, the hospitals don't see them, and the doctors don't see them. So if we don't see them anywhere, we suppose they don't exist," Dr Brussel explains.

The city and the police make a sharp distinction between cannabis — which is openly sold in "coffee houses" — and opiates and cocaine. Police immediately close a "coffee house" which tries to sell any drug but cannabis.

Dr Brussel and his colleagues have a close working relationship with the police, and one of their physicians sees every drug user who is arrested. If there is any threat of violence to a staff member, the police immediately respond.

"People tend to be aggressive, and we know some methadone is sold on the streets. So there are certain people we don't want to give it to, but still they insist on coming," he adds with a sigh. The street market for methadone is among foreigners who cannot get the drug from clinics.

Dr Brussel thinks there is a lot of cocaine in Amsterdam, but it is mainly confined to heroin users. "About 70% of the heroin users use cocaine — if they can — as sort of a dessert. We have not seen any crack, and we have not seen many 'normal' people with cocaine problems. I do not think it is attractive to the Dutch culture, and we are lucky with that."

■

Dr Brussel would have liked to continue distributing free condoms to IV drug users and their partners. But it has proven financially prohibitive, and there is now a small charge. For now, it appears there is no HIV infection among non-drug-using prostitutes, but it is probably high among both male and female drug-using prostitutes, he says.

Dr Brussel observes: "It appears to us that many drug users are motivated to use clean syringes because of concern for their health. We know it is always being talked about among users. Most prostitutes want to use condoms but many of their client's don't, and we have an educational problem there."

■

When time and the HIV virus start to take their toll among drug users, Dr Brussel is considering ways in which experimental AIDS drugs can be administered in this population. Because the Netherlands, like most of Western Europe, has a national health service system, the researchers will be able to work closely with hospitals.

"You will have to reach certain populations to control AIDS effectively, which means if you give out dangerous drugs, you have to be sure they are taken properly and research is done into side-effects.

"In most other countries, the drug population is a forgotten group: people say you cannot reach them effectively. I think that here, with our system of methadone maintenance and control and containment as such, we can provide a good medical background for treatment."

Couples mark their needles 'his' and 'hers'

(from page 7)

city stopping at certain times of the day, every day; or they come regularly to the clinic.

Tests have shown 30 of his clinic patients HIV-positive, and Dr Kanhai suspects four others are developing the first signs of ARC.

He has told those who are seropositive: " 'This doesn't mean you will get AIDS. But it does mean you have got to change things and try to help your immune system.' We try to give a lot of social help as well as medical help. And, we tell them if they change their way of living, they may live a long time."

Outside his office are several cases of sterile needles, a large black garbage can full of used needles packed into plastic bags, and a condom machine — three for one guilder (about 40 cents). "We gave out condoms free, but it is too expensive. And they complain about spending a guilder for three, even though they would cost a lot more on the open market."

The message to addicts is: use these clean needles and never throw them away, exchange them. And every time addicts come to exchange needles, Dr Kanhai and his staff talk to them. He is unconcerned if someone exchanges used needles for clean ones and then goes out to sell them. "I don't care. The thing is to get them to use sterile needles."

Dr Kanhai has seen no evidence that distribution of free needles has changed the pattern of drug use in his patients, and there is no sign at all of people turning to IV use because they can get sterile needles. "My clinical impression is that a lot of people are changing their habits and are using their own needles instead of sharing. We even have couples who mark their needles, sort of 'his' and 'hers.' "

Dr Kanhai: "We have a lot of patients who are seropositive and who have connections in normal society, and we impress on them that they have to be careful and use a condom."

Less straightforward, but a challenge he meets head on, are Dr Kanhai's excursions into the twilight world of prostitution. It is not the professionals sitting in their "cabins" in the well-defined, red-light district of the city who are the major worry. Rather, it is the men who control them.

Kanhai: into a twilight world

"Most of these women use condoms. But we are trying to set up a special program to reach these men to tell them if their girlfriends are prostitutes they had better be careful, and if they have more than one girlfriend, as most do, they can not only get the HIV virus but also spread it.

Easier are the calls at houses of prostitution which usually have from 10 to 12 women working there. Dr Kanhai talks to the proprietors to impress on them the need for condom use.

He and his colleagues also try to work with male homosexual prostitutes to sell the message of safe sex.

Dr Kanhai has a special problem in his own clinic district, Surinamese women who rent small rooms in high-rise apartment blocks. "They are both prostitutes and heroin users, but they don't need methadone because they make enough money to buy their dope. Reaching them is very difficult."

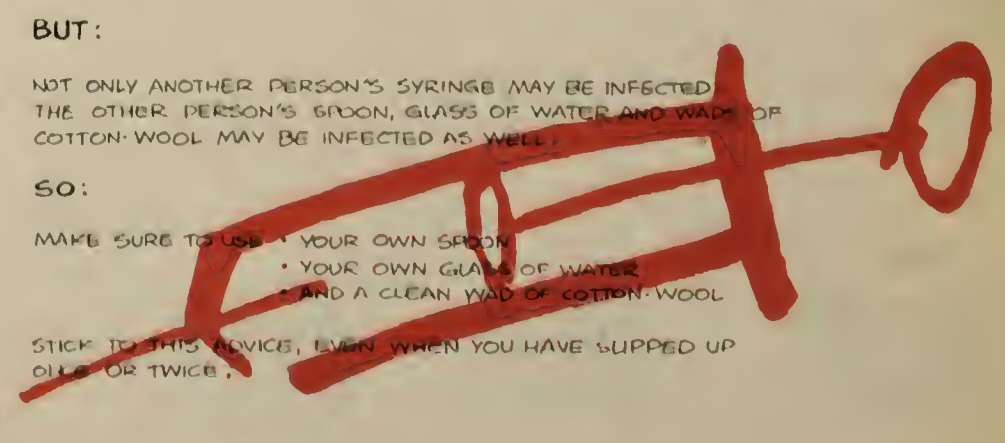
His clinic is filled with posters and pamphlets and leaflets. One of the most incisive (see graphics this page and page 7), printed in eight languages, uses cartoons and blunt language to sell the idea that a condom is essential. A condom is enclosed. "We give them out to clients, to people in the red-light district, in fact to anyone who comes into contact with prostitutes."

Dr Kanhai believes "while we can't prove that our program of needle exchange is slowing down the spread of the HIV virus, I think it is helping in some ways to stop transmission. Certainly a lot of people are changing their habits, and that is good."

With that, Dr Kanhai is off into the night to continue working: it is his turn on the rota to visit police stations around the city to check on any drug users who had been arrested during the evening. He and his colleagues work closely with the police and impress on them the need for caution about both AIDS and hepatitis infection

The Journal

Addiction Research Foundation
33 Russell St, Toronto M5S 2S1



VOL. 1 NO. 3 OCTOBER 1987

INSIGHT

by Joan Marshman, PhD

'At ARF we recognized the need for a specialized, authoritative source of information . . . designed specifically for Ontario'

ADDICTION RESEARCH FOUNDATION'S ONTARIO REPORT

Do you know when you're 'over 80'?

Ten signs of intoxication

Pages 2/3

Server intervention: a new approach to alcohol education

TORONTO — When a young person comes into a bar and shows a high school I.D. card, should he, or she, be served alcohol?

This is the kind of question encountered by participants in a new Addiction Research Foundation (ARF) course. The Server Intervention Program (SIP) is spreading the news to the hospitality industry that serving liquor involves risks and responsibilities.

SIP is winning province-wide support for its timely message.

For more on the program, see pages 2 and 3.

Treating young drug abusers

TORONTO — The Addiction Research Foundation (ARF) is playing a leading role in the treatment of drug addiction among Ontario's young people.

ARF's Youth Clinic in Toronto offers a wide choice of treatment services for its clients, who range in age from 12 to 25 years.

ARF staff match treatment to the individual needs of the young drug abuser, who may opt for short-term counselling, a four-week intensive program, or a combination of other therapies.

Meanwhile, ARF is breaking ground in its research on adolescent drug abuse.

ARF is conducting in-depth studies to discover more about who is likely to start taking drugs — and what kind of treatment will have the most impact.

Youth clinic staff: meeting the need

For more on youth treatment, see pages 2 and 3.
For a report on drug use in Ontario schools, see page 4.

Award presentation: Don Colbourne (left) with ARF chairman John B. Macdonald (right) and deputy police chief William Kerr

ARF expands awards program

TORONTO — Starting this year, the Addiction Research Foundation (ARF) is expanding its community awards program. Now there are two award categories and the winners will be announced next month.

The Provincial Award of Distinction recognizes province-wide community work by individuals; the Regional Award of Community Achievement is reserved for those individuals who are serving their community or region.

"We wanted to recognize the terrific work that people do outside the Addiction Research Foundation," says Henry Schankula, director, Inter-Organizational Affairs. "There has been some outstanding achievement in the private sector and in organizations that work with us throughout the province."

Nominees for the awards are chosen because they have:

- contributed to the alcohol and drug dependence field, particularly in community service, education, and prevention;
- worked closely with ARF and supported its goals; and,
- earned the respect of their communities and colleagues for their efforts.

Award winners will be named during Addiction Awareness Week, November 15 to 21. Look for an announcement about this event in an upcoming issue of **Ontario Report.**

The ARF awards were launched last year, when Toronto's Sergeant Don Colbourne was honoured for his dedicated work with Reduce Impaired Driving Everywhere (RIDE).

Sister St Patrick Joyce also won an ARF award in 1986, in recognition of her 45 years in the treatment and rehabilitation of alcoholics.

Sister St Patrick Joyce

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Youth Clinic — positive peer pressure

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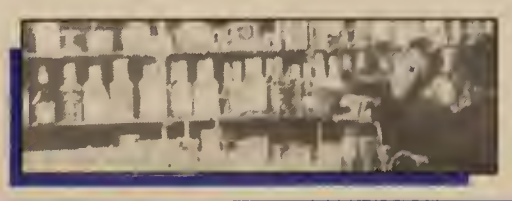
Teaching the servers — risks and responsibilities

pages 2/3



What When Where

page 4

INSIGHT

ONTARIO REPORT: WHY NOW?

We live in an information age. This can be a blessing — we have never been able to get important information so quickly and easily. But it can be a headache as well. We are constantly flooded with information rushing in from around the globe. The volume makes it almost impossible to sort this deluge — much less to analyze its relevance for Ontario. Our knowledge of the world has become as fragmented as the 20-second clips on TV news.

This is as true in the addictions field as in other areas of our society. At ARF we recognized the need for a specialized, authoritative source of information, both for professionals and for interested lay people, a source of information designed specifically for Ontario.

ARF's staff are constantly receiving and critically analyzing information from around the world. They're constantly identifying new ideas that are compatible with Ontario's needs and perspectives. They're constantly incorporating the "best of the new" into programs in Ontario. ***Ontario Report*** was created to share these new ideas and developments with the people of Ontario.

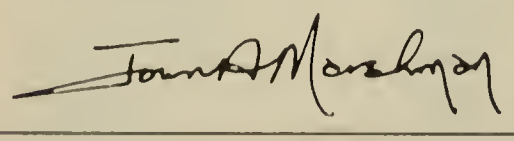
This is the third issue of ***Ontario Report***. We want to make an important contribution to the field. Clearly, it will also create a powerful focus for ARF's work in coming years.

I am proud of ARF's reputation for expertise and leadership. But we are not about to rest on our laurels. In the next decade ARF will be pursuing an ambitious, revitalized program of research, treatment, and health promotion. As part of this program we have increased our commitment to working with people across Ontario. Together we will attain our common goals.

Communication is an essential means of working together for change. ***Ontario Report*** will help keep the channels of communication open. We will use ***Ontario Report*** to keep you up to date on developments in understanding addictions, in addictions treatment, and in prevention and health promotion.

It will help you access the information, advice, and resources ARF has to offer. Most of all, ***Ontario Report*** should contribute to a better working relationship between ARF and you.

Why did we create ***Ontario Report*** ? To meet Ontario's real needs. At ARF, we are committed to doing just that.



Joan A. Marshman
President, ARF

ADDICTION RESEARCH FOUNDATION'S
ONTARIO
REPORT

Published by the Addiction Research Foundation

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Treating drug abuse an

TORONTO — A specialized treatment program designed by the Addiction Research Foundation (ARF) is helping young people to overcome drug abuse.

The Youth Clinic at ARF is one of the few centres in Ontario to offer treatment services tailored to the adolescent drug abuser. Clinic clients range in age from 12 to 25 years, and the majority of them are abusing more than one drug.

"Alcohol and cannabis is the most common combination in younger drug users," says Garth Martin, head of Sociobehavioural Treatment Services at ARF. "But cocaine is starting to replace cannabis in second place."

ARF's Youth Clinic opened in October, 1986. Adolescents have been treated at ARF for more than 15 years, but up until last year they were included in the general program.

"We decided young people had particular needs and shouldn't be lumped in with adults," says Mr Martin.

To meet those special needs, the Youth Clinic is staffed by professionals with expertise in the treatment of adolescents. Services include clinical assessment, counselling, outpatient treatment, residential care, and day programs. As well, the drug user's family is offered resources such as counselling and consultations.

Contrary to popular opinion, the best form of treatment for young drug users is a day program. Drug rehabilitation centres that focus on overnight inpatient care are well publicized, but they are not the norm.

"It's a myth that most adolescents attend residential treatment centres," says Mr Martin. "In fact, 80% of American adolescents are treated in outpatient drug-free programs."

The Youth Clinic's day program emphasizes personal responsibility. Whether treatment is short-term or intensive, young people are encouraged to acknowledge their drug problems and recognize the consequences of this lifestyle.

"There is no quick fix," says Ed Watson, director of the Clinical Institute at ARF. "We give our clients a variety of strategies and we encourage them to take charge of their own lives — to make choices."

For a teenager with a drug problem, pragmatic strategies are often highly effective. Learning time management, for example, can help the teen to avoid school crises that may trigger an episode of drug use. "Young drug users aren't exposed to the learning opportunities that equip other kids with life skills," says Elsbeth Tupker, head of the Youth Clinic. "We have to fill the void and offer them the tools they need."

Treatment approaches at the Clinic are founded on extensive research. Previously, adolescent drug abuse has not been widely studied; ARF has been a pioneer in the field. Too often, says Mr Martin, treatment strategies for this particular population through intuition and of relying on sound scie tion.

The Young Drug Abu ducted by Mr Martin a kinson, PhD, head of Sc Research, is one curre ARF's efforts in youth tre

This research project kind in North America examination of effec styles. It is not yet comp to date are reinforcing A that outpatient treatmer ter results.

The principle of exc ment lies at the heart research activities. "W the leading edge of you search," says Mr Watso key resource for others

Young people: taking char

Watson

A profile of the young drug user

True or false? Drugs cause school problems, family conflicts, and even delinquent behavior among young people.

True, suggests conventional wisdom. But false, say the research studies on drug abuse.

Drugs certainly aggravate such problems. In general, however, the problems exist *before* the adolescent starts taking drugs.

The typical teen, prior to drug use, has:

- **a parent with an alcohol or drug problem (about 40% of young drug users fall into this category),**
- **behavioral problems, possibly including deliquency,**
- **family conflicts,**
- **low self-esteem,**
- **a record of poor school performance, possibly including learning disabilities.**

Serving the public with care: A

TORONTO — Responsibility is the message behind a training program developed by the Addiction Research Foundation (ARF) and targeted to the hospitality industry.

ARF's Server Intervention Program (SIP), launched in October, 1986, is underlining the obligations of hotel, restaurant, and tavern staff when they serve alcohol to their customers.

"People in the industry need to be aware of their vulnerability to lawsuit and the provisions of the Liquor Licence Act," says Suzanne Brunet, ARF's provincial coordinator of the Server Intervention Program.

Recent legal action indicates establishments serving liquor are increasingly being held responsible for accidents resulting from excessive drinking.

In one Ontario case, for example, a drunk driver was involved in a car accident that left his passenger a quadriplegic. The passenger launched a $13 million lawsuit against not only the driver, but also the hotel that had served him alcohol.

The courts decided the hotel was liable because the staff should have recognized the customer's impaired state.

Verdicts like this one are persuading the hospitality industry to protect itself and its customers.

"Suits are costing thousands of dollars," says Robert Solomon, a law professor at the University of Western Ontario. "The insurance industry is going to start putting pressure on the industry too."

The Server Intervention Program addresses the legal issues that concern the industry and also outlines facts about alcohol, including how intoxication occurs and how to recognize it (see below).

Then, program instru trainees with a set of can use to prevent in lems or cope with the occur.

They might offer lov to their patrons, for ex low-salt, high-protein offset the effects of al tion.

Staff are also told ho

Ten signs of intoxica

1. **Slurred speech**
2. **Red eyes**
3. **Sweating**
4. **Decreased alertness**
5. **Changes in speech volume**
6. **Changes in speech pace**
7. **Decreased fine motor control**
8. **Decreased gross motor control**
9. **Slow or shallow breathing**
10. **Sleepiness**

- **Participants in the Server Intervention Program learn how to recognize the symptoms of excessive drinking.**

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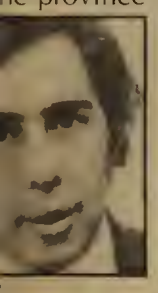

who are at work in the same field.

"Our research goal is to enrich our treatment," he says. And Mr Martin adds, "If you believe in your clients, you want to evaluate the treatment you provide so you can do the job better."

While the Youth Clinic is housed at ARF's Toronto headquarters, ARF's expertise in youth treatment is reaching into communities around Ontario as well.

Consultants in ARF's 33 branch offices maintain close ties with institute staff and are active in advising communities on appropriate programs for young drug users.

Outreach programs are creating liaisons with community groups, such as Parents Against Drugs (PAD), to build awareness about ARF's youth programs. And, within the schools, a prevention program staffed by ARF's consultants educates students and teachers on the dangers of drug abuse.

But the treatment currently available in Ontario for young drug abusers is still not adequate, says William Becks, divisional program consultant on treatment services with ARF's Community Services Division. "We see cases where young people from our province go to the United States for treatment, because there aren't enough facilities here, or the waiting lists are too long."

The impact of drug abuse, of course, is not limited to the young drug user alone. It can be a disturbing influence on the entire family and the Youth Clinic at ARF encourages families to become involved in the treatment program.

They may, for example, attend family meetings at the clinic, where the adolescent's drug use is placed in the context of his or her home life. What is provoking the drug use? Do the parents need to assert more control? Does their son or daughter need more freedom?

Often, only short-term family counselling is necessary, as parents learn to cope with a child's drug problem, to support his or her efforts to stop, and to capitalize on the family's own resources. A few telephone conversations with an ARF therapist may be enough to weather a brief crisis.

"Parents need to know," says Mr Martin, "that one episode of drug use doesn't mean a child will become a drug addict. We reassure them that it is a very common problem and that they shouldn't over-react.

"The important point is not the incident itself, but how it is dealt with."

Approximately 500 young people, from students to street kids, come through the clinic's doors each year. Mr Martin estimates that 67% are treated successfully, but he cautions that success does not have to mean a totally drug-free lifestyle.

"Some experts say if you're not advocating abstinence, then you're advocating use. But the evidence doesn't support the idea that people go into treatment and stop drugs cold. It happens gradually.

"We look at how the person's life has changed. There may still be occasional drug use. But if he's back in school, or living at home, or able to work, then that's an achievement. Our objective is a change for the better."

Inside a drug treatment program

Positive peer pressure

TORONTO — When adolescents join ARF's Young Drug Users Program, they sign on for four weeks of intensive treatment streamlined specifically to their age group.

The first week of the program, run by ARF's Youth Clinic, investigates each person's drug-taking pattern. In groups of from three to five, headed by ARF therapists, participants discuss their personal patterns and start to work out their treatment goals. What circumstances trigger the drug use? How can they avoid these situations?

Young people cannot take any drugs while they are in the program and they are asked to monitor their cravings for the drugs they are trying to quit.

"Cravings are high-risk moments, the time when drug-taking is most likely," says Elsbeth Tupker, head of the Youth Clinic. "We teach them to cope with the cravings by coming up with alternatives, like exercise, or seeing their friends."

Group sessions are a springboard for such discussions, but this is only one part of the group's task.

The program employs a credit system, in which each group earns points on a daily basis. Punctuality, for example, can earn a group points that can be exchanged for free time or items at the tuck shop.

Because one person's actions thus affect the group as a whole, group members are motivated to behave responsibly toward one another and peer pressure — so prevalent in adolescent drug abuse — has a chance to exert a positive influence.

Program participants also take part in a full range of daily activities. These include:

- **Relaxation training — demonstrating stress management**
- **Leisure counselling — providing guidance on constructive use of free time**
- **Vocational counselling — to help individuals return to school or enter the job market**
- **Recreational activities — physical education programs**
- **Health promotion — educating young people on healthy lifestyles, sexuality, and medication-free pain control.**

Skill-building is stressed in each facet of the program, as adolescents learn how to solve problems and develop confidence in their personal resources.

One teenager, for example, may find a place to live by plugging into community agencies. Another might enrol in a YMCA course that could lead to better social skills and a new network of friends.

Ideally, each graduate of the Young Drug Users Program knows how to adopt a drug-free lifestyle and is motivated to do so.

The program comes to a close with counselling on how to prevent a relapse, and arrangements for follow-up care with an ARF counsellor.

"We tell our clients that a relapse doesn't mean failure," says Ms Tupker. "If they slip up, it is something they can overcome — and then they can get right back on track."

Tupker

RF course highlights risks and responsibilities

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customer's liquor intake and cut down on service if necessary.

When customers do drink excessively, it is essential that safe transportation is provided for them. Legally, establishments cannot serve a customer to the point of intoxication, so if an accident happens after the customer leaves, the server's liability risks are high.

SIP recommends that a "house policy" spell out the staff's strategy in such a situation: the bar owner may call a taxi, for example, or even ask a staff member to drive the customer home.

The Liquor Licence Board of Ontario (LLBO) is strongly supporting SIP. The Board offers an abbreviated version of SIP in its orientation sessions for liquor licence applicants.

"The Board wanted to do more to alert licencees to their responsibilities," says Len Griffiths, director of licencing and permits at the LLBO. "The Server Intervention Program gave us the opportunity to get the ball rolling."

Endorsed by the Ministry of Consumer and Corporate Relations, SIP is meeting with an enthusiastic response from the hospitality industry itself.

"We are recommending it to all our members," says Robert Woolvett, executive vice-president of the Ontario Hotel and Motel Association (OHMA). The OHMA has a membership of 1,600 and is actively publicizing SIP.

"It's an excellent program and it's a sign of the times," says Mr Woolvett. "Our members are becoming more aware that their responsibility has increased."

The Ramada hotel chain, for instance, is planning to train staff members in its 16 locations across the province.

PAFCO, an Ontario insurance company, has made the Server Intervention Program mandatory for licensees seeking insurance coverage.

"We reimburse 50% of the program's cost," says Robert Tisdale, Branch Manager at PAFCO. "When we realized many of our liquor-related claims were not restricted to drinking and driving, we decided we needed a program that covers all aspects of the drinking issue."

Costly lawsuits and escalating insurance premiums may be strong motivations, but they are not the only factors fuelling the hospitality industry's growing interest in SIP. A new public awareness about the dangers of drinking and driving, for example, is having a positive effect.

"And the industry," Ms Brunet points out, "also appreciates an image as a good corporate citizen."

To date, 900 people, including owners, managers, bouncers, bartenders, waiters, and waitresses, have completed the Server Intervention Program. ARF is currently planning to make SIP more widely available throughout the province.

For more information on when SIP's seminars will be available in your area, contact:

Suzanne Brunet
Program Coordinator
Community Services Division
Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S 2S1
(416) 595-6046

Standard drink limits:

This chart is a guideline to alcohol consumption developed by the Server Intervention Program.

The aim is to keep blood alcohol levels below the 80 milligram (per 100 millilitres of blood) limit that is the current benchmark for intoxication. The guidelines cover a six-hour period, and the number of drinks recommended per hour is based on the drinker's gender and weight.

Standard Drink Limits To Remain Under 80 mg%

Hours	Weight (pounds)	Male	Female	90	100	100 120	125 150	150 180	175 210	200 240	225
1				1	1	1	2	2	3	4	5
2				.5	.5	1	1	1	1	1	-
3				.5	.5	.5	.5	1	1	-	-
4				*	.5	.5	.5	1	-	-	-
5				.5	.5	.5	.5	-	-	-	-
6				.5	.5	.5	.5	-	-	-	-
Total				3	3.5	4	5	5	5	5	5

*** If no drinks are consumed in the fourth hour of drinking, an additional .5 of standard drink can be consumed in each of the fifth and sixth hours, giving a total of three standard drinks in the six hour period.**

ARF survey: good news on student drug use

TORONTO — While the media insists a drug crisis is raging in North American high schools, the statistics for Ontario schools paint a far brighter picture.

Drug use among Ontario students seems to be declining, suggests a survey by researchers at the Addiction Research Foundation (ARF).

The study examined drug use trends across the province between 1981 and 1985 and notes a downward shift in many of the drugs studied.

Reginald Smart, PhD, director, prevention studies was principal investigator for the initial study on school drug use. Michael Goodstadt, PhD, former chief, education research program, and Edward Adlaf, senior research assistant, were the co-authors.

Authors of the subsequent trend analysis were Dr Goodstadt, Margaret Sheppard, research associate, and Margaret Willett, senior research assistant, also in education research.

Alcohol and tobacco use has dropped since 1981, the study shows. Out of a total of 17 drugs, eight showed a significant decline in use. In 1981, 8% of Ontario students reported that they had taken barbiturates at least once in the previous year. But in 1983, 6% made the same claim — and that number dropped to 4% in 1985.

The ARF survey, which began in 1977, canvasses student drug use every two years. The 1985 report surveyed 4,154 students from across the province.

Goodstadt: 'there is more hype about drugs in the media than is justified'

Cocaine and heroin use remained at low levels, and reported tranquillizer use dropped to 3% from 5%. Stimulant use went down to 12% from 15% in 1983.

Alcohol still top

Alcohol remains the most popular drug in the 193 schools surveyed. In 1985, 70% of students reported alcohol use in the previous year. Moreover, about 5% of all students surveyed wanted to curb their current level of drinking.

Tobacco and cannabis came second and third in popularity, but they lag far behind alcohol. Twenty-five percent of the students said they had smoked at least once in 1984, while 21% had used cannabis.

These figures are lower than those reported in 1983, when the percentages were 29 and 25, respectively.

Because students are surveyed by grade level, their drug-taking patterns are traceable. The survey suggests drug use (with the exception of alcohol) generally peaks in Grade 11 and is down again by Grade 13.

Why are fewer students using drugs?

"We'd be millionaires if we knew the answer to that question," says Margaret Sheppard, co-author of the study. But she speculates education campaigns and prevention programs are leaving their mark, along with a growing interest in healthy lifestyles.

"And parents are role models for their children," she says. "Kids learn drug-taking from their parents. So when drug use declines among adults, as it has now, we see a decline among their children too."

Media attention

The media may also play a part, says Dr Goodstadt. "There is more hype about drugs in the media than is justified. But one could argue that the reduction in drug use may be related to the concern that the media expresses about it.

"It may not be a cause for the decline, but the media attention could reinforce it."

The trends noted among Ontario students mirror those found in surveys of United States high school seniors.

The Ontario survey also examined drug education in the schools. Drug education classes can include films, group discussions, and lectures from guest speakers such as drug experts or ex-drug users.

Although the majority of Ontario school boards include drug education in their curricula, only 29% of the students reported they had more than two classes in the previous year.

Sheppard: 'you have to show them drugs can interfere with their lives now'

This does not necessarily indicate the schools are not allotting enough time to the subject. Ms Sheppard points out that many students simply don't remember the classes they have had.

"For us, this survey is ammunition. We can go to the school boards and show them that the current program isn't having enough impact."

The real challenge in drug education, adds Ms Sheppard, is to reach the high-risk student — the teenager who is already taking drugs.

Relevant concerns

"We have to be relevant for this group, to get them to recognize that drug use is a problem for them."

Talking about long-term health risks does not impress these young people. "You have to be immediate," Ms Sheppard says, "to show them that using drugs can interfere with their lives right now. If they go to a rock concert on drugs, for example, they'll enjoy the first hour. But we tell them that after that, their perceptions will be distorted and they'll miss the rest of the music. That's the kind of approach that has an effect."

NEW from ARF

Applause — A Presenter's Guide to Parent Education about Alcohol and Other Drugs

This manual is for anyone involved in parent education in the drug/alcohol field. It includes sample presentations to increase parent awareness of strategies for preventing, identifying, and coping with drug use among youth.

The manual also includes background reading material on the drugs most commonly used by young people and information on methods and techniques designed to help presenters answer questions. Overhead graphics are also included.

For more information: *Marketing Services, Dept OR, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1. 98-page, 3-ring binder, $9.75.*

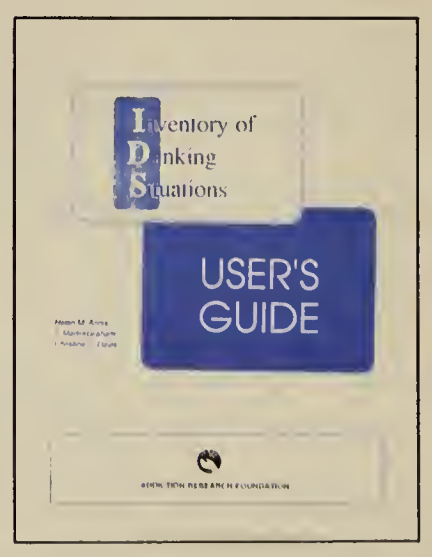
Inventory of Drinking Situations

The Inventory of Drinking Situations is a new treatment planning tool to help addictions workers identify clients' high-risk areas for drinking relapse.

Developed at the Addiction Research Foundation, the package includes a 50-page interpretive user's guide, and a 100-item questionnaire (IDS-100) to assess eight categories of drinking situations: unpleasant emotions, pleasant emotions, physical discomfort, personal control, urges and temptations, conflict with others, pleasant times with others, and social pressure. There is also a shortened version (IDS-42) for research applications.

The package is available as paper and pencil carbon-set questionnaires or interactive software.

Order from Marketing Services, *Dept OR, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1. (416) 595-6056. User's Guide, $13.50. Questionnaires: IDS-100, $14.75 pkg 25; IDS-42, $12.75 pkg 25. Specimen set: User's Guide and 25 IDS-100 questionnaires, $25. Call for information about software.*



What When Where

Mixed Reactions: Seniors, Alcohol and Drugs — October 8, 7:15 - 9:15 pm, New City Hall, Toronto. The Addiction Research Foundation, in cooperation with the Mayor's Committee on Aging, presents a public forum on the use and abuse of alcohol and other common drugs by seniors. Panelists include Dr Sally Saunders, ARF. Free admission. Contact: Donna Heughan (416) 595-6102.

Identification & Management of People with Drinking and Drug Problems — October 20, Talisman Motor Inn, Ottawa. This one-day workshop for health professionals is sponsored by the ARF Ottawa/Carleton Centre, the Addiction Research Foundation's School for Addiction Studies, and the Royal Ottawa Hospital. Contact: Virginia Carver (613) 722-1075.

Drug Abuse: Epidemic or Smokescreen — October 29-30, Holiday Inn, Toronto. The Drug Education Coordinating Council's 5th annual conference will include a workshop on chemical use "From Innocence to Dependence," by Harold Kalant, ARF, and on drug education for Grades 4 to 8, by Gloria Silverman. Contact: Larry Hershfield (416) 595-6020.

Drug Use and AIDS — November 12, 7:30 - 9:30, ARF Auditorium, Toronto. The Addiction Research Foundation presents a public forum on drug use and AIDS. Free admission. Contact: Donna Heughan (416) 595-6102.

Starting Early — October - November. The ARF London Centre, in conjunction with the London Board of Education, will be implementing an alcohol and safety awareness program for students in kindergarten through Grade 6. Teachers will also receive in-service training from ARF consultant Maeve Connell about children of alcoholics to help identify and assist students with problem-drinking parents. Contact: Maeve Connell (519) 433-3171.

Hot tubs, alcohol bad mix

By Paul Szabo

LAS VEGAS — Too many drinks and an overheated hot tub can be a devastating combination, a West Virginia researcher has found.

In a study reported here at the annual meeting of the American College of Sports Medicine, Thomas Allison, MD, director, Cardiac and Wellness Center, Wheeling Hospital, Wheeling, West Virginia, found having just a couple of drinks had no impact on subjects using a hot tub heated to the recommended temperature.

But, he also found someone using an overheated hot tub after consuming the same amount of alcohol becomes physically ill.

Dr Allison decided to evaluate the impact of alcohol on hot-tub users after reports of 36 deaths following hot-tub use in the United States and another report on the doubling of emergency room visits by hot-tub users over a one-year period.

While there was no systematic reporting of alcohol involvement with the fatal cases, he told **The Journal** the deaths were associated with alcohol consumption in at least 50% of cases.

In their experiments, Dr Allison and associate William Reger asked volunteers to stay in a hot tub for 21 minutes. In three trials, the tub was heated to the recommended temperature of 40 degrees C; in another trial, it was heated to 41.5 C. Fifteen minutes prior to using the hot tub, the subjects were asked to consume drinks containing either no alcohol or one of two levels of alcohol — the highest producing a blood level of 0.08%.

A variety of physiological and psychological measures were taken, and Dr Allison found there were no significant differences with subjects using the correctly heated hot tub, regardless of their alcohol consumption. A trend was seen toward more changes in sweat rate and symptoms of discomfort with higher alcohol consumption.

When subjects used the overheated tub without consuming any alcohol, their heart rates, body temperatures, and sweat rates all accelerated faster, and they reported being uncomfortable prior to the conclusion of the experiment.

The most dramatic changes in physiologic measures were seen when subjects got out of the hot tub; their heart rates increased, and their blood pressure dropped dramatically.

To test the combination of drinking and using an overheated hot tub, Dr Allison ran a couple of preliminary experiments. He found that after consuming the equivalent of three drinks and using a hot tub heated to 41.5 C, neither subject was able to complete the experiment: one volunteer vomited after 12 minutes.

"It really seems that water temperature may be a more critical variable than the alcohol," said Dr Allison.

Despite finding few differences between those who had consumed alcohol prior to the experiment and those who had not, Dr Allison did not discount the effect of alcohol.

Spotlight on sports stars inhibits rehab

By Paul Szabo

LAS VEGAS — Publicity is the worst thing that can happen to a professional athlete with alcohol or other drug abuse problems; and, conversely, confidentiality is the key to successful management of these problems.

That's the opinion of John Lombardo, MD, a team physician for the Cleveland Cavaliers basketball team and an expert on drug abuse in sports.

At the annual meeting here of the American College of Sports Medicine, he and his colleagues, John Bergfeld, MD, and Gregory Collins, led a symposium on recreational drugs and athletes.

Drs Lombardo and Bergfeld told **The Journal** alcohol and other drug abuse in professional sports is being brought under control in large part because of the changes in society itself.

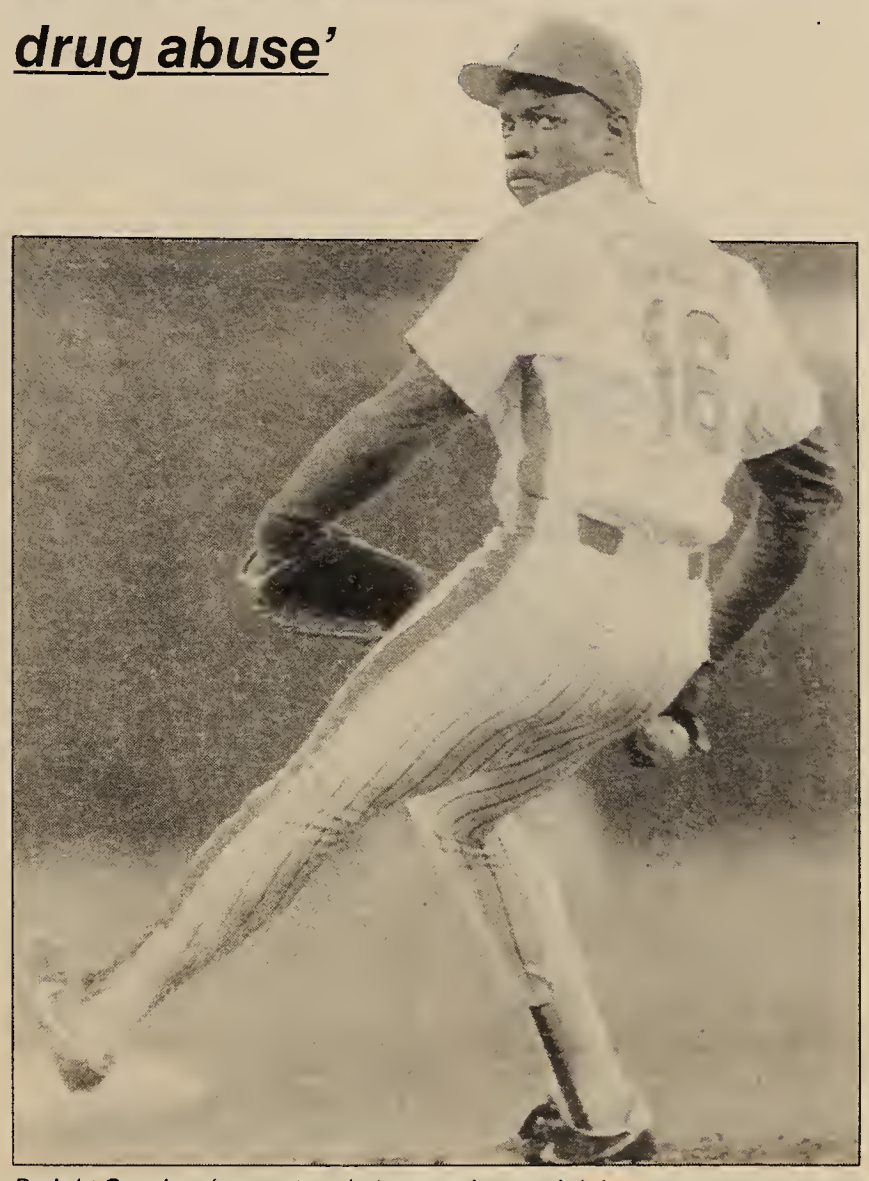
But, they made it clear high-profile cases of athletes abusing drugs do nothing to help the athletes involved and are not vital to changing the behavior of other professional athletes.

"I believe that the professional athlete is changing his activity because of his desire to be a good citizen," said Dr Bergfeld. There is "no question" these athletes are becoming more sensitive to the issues surrounding drug and alcohol abuse.

Dr Lombardo said once an athlete's drug-use problem becomes public, it's harder to treat that athlete because of the stigma attached.

"Dwight Gooden is going to have a very tough time staying straight — extremely tough," he said. Mr Gooden, a pitcher for the New York Mets, was suspended for cocaine use prior to the beginning of this year's baseball season; he is now playing again following treatment.

'There is no question professional athletes are becoming more sensitive to issues surrounding alcohol and other drug abuse'



Dwight Gooden: 'a very tough time staying straight'

The same quandary faces National Basketball Association players who have had their drug problems publicized.

Dr Lombardo pointed to the Cleveland Browns football team as one that has organized a successful treatment program in which players have been treated without the problems becoming public.

Early identification is a key factor in successful treatment, he said, adding it also decreases the chance of the situation becoming public.

Dr Lombardo: "The idea is to get them into treatment . . . during the off-season.

"If you wait until they have to go into rehabilitation and it's in the season, you're finished."

Dr Bergfeld, who is involved with the Browns, the Cavaliers, and the Cleveland Indians baseball team, said team physicians are getting better at spotting problems and making early diagnoses.

But, Dr Lombardo said making the diagnosis can be difficult because the signs and symptoms of abuse are subtle. For this reason, he would prefer team physicians to have the right to test athletes for drug abuse: "We need a screen," he said.

Tests should be considered "in the same way as any other (medical) screening test," when there is a suspicion of a problem. But, he admits the legal dimensions of drug testing complicate the issue.

On the positive side, peer pressure has been identified as a strong factor today in getting athletes with problems into treatment.

"The athletes are educated about drugs and the educational process has paid off immensely," Dr Bergfeld said.

They can be key to early diagnosis

Gynecologists need alcoholism info

By Paul Szabo

DENVER — Gynecologists can play a key role in the early diagnosis of female alcoholism and should be given the information they need to do so, says an expert on women and alcoholism.

Sheila Blume, MD, medical director, alcoholism and compulsive gambling programs, South Oaks Hospital, Amityville, New York, gave the advice to delegates at the 1st National Conference on Women's Issues here.

"Reach out to the primary care providers," she said, since all women have some source of gynecologic or other primary care.

When provided with the proper information, gynecologists should be able to identify alcoholic women patients and refer them for proper treatment. "Screening is not difficult," she said.

Educating primary care providers is one way of correcting the current underdiagnosis of alcoholism in women today.

All of the best early interventions — employee assistance programs and the court system — are more successful in targeting male alcoholics, Dr Blume said.

But, women problem drinkers are more likely to have problems with families and health than with work or the courts; the best place to detect them is in doctors' offices and health clinics.

A recent study at Harvard Medical School confirms this hypothesis.

Researchers at Harvard looked at two gynecologic practices in the Boston area; patients tended to be in their 30s and highly educated. Of 147 patients who attended for routine gynecologic care, 12% had a problem with alcohol.

Of patients attending a premenstrual syndrome clinic, 21% qualified for a diagnosis of alcoholism.

Another speaker at the conference also zeroed in on the role of the physician in diagnosing alcoholism.

"Physicians are not making the diagnosis of alcoholism," said Fern Asma, MD, director, occupational medicine, Parkside Medical Services, Denver, Colorado. "They're still continuing to treat the symptoms."

She said there has been some progress made in educating doctors to consider alcoholism as a possible cause of female health problems, but progress has been slow.

Gynecological care: in one study, 12% of 147 patients had a problem with alcohol

INTERNATIONAL

Israeli cabinet asks Shamir to head up ailing drug war

JERUSALEM — The Israeli cabinet has set up a ministerial committee under Prime Minister Yitzhak Shamir to look into establishing a statutory authority to coordinate all official and volunteer bodies in the drug field in this country.

The move follows sharp criticism of the government several weeks ago for failing to follow-up on its pledge to wage a nationwide "war on drugs" in 1987 (**The Journal**, September).

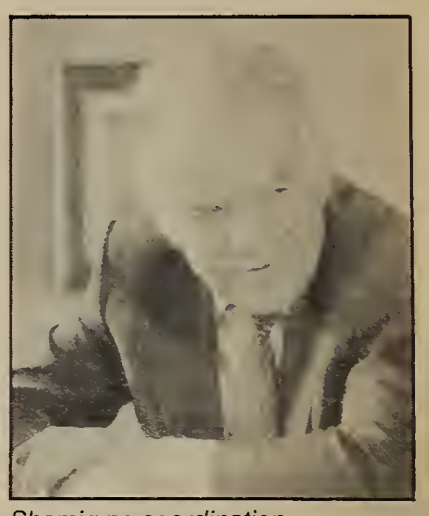
The criticism came from Israel's state comptroller, who charged that the government had failed to coordinate efforts, ineffective as they were, among various relevant ministries, including health, social welfare, the police, and defence forces.

Reports at the cabinet meeting can be divided into facts and intelligent guesses. The facts state that 830 people received methadone in 1984 compared to 4,200 in 1987; 30 died of drugs in 1984 compared to 52 in 1986; and the police opened 2,567 files (mainly against pushers) in 1985 compared to 3,029 files in 1986.

The "intelligent guesses" by various cabinet ministers and/or police placed the number of "hard-drug" addicts at 10,000 or 15,000 and the number of regular or occasional users of all drugs at between 100,000 and 200,000.

Police believe the drug trade now costs the country one billion dollars a year (about 4% of the gross national product), and that an estimated 40 tons of 1,000 tons of hashish shipped from Lebanon to Egypt (mainly by sea) was diverted to Israel.

They also estimate about 400 kilograms of heroin is now entering Israel annually, compared to only 80 kg in 1982.



Shamir: no coordination

Equal voice to governments, employers, workers

ILO votes to add drugs, alcohol to its agenda

GENEVA — The International Labour Office (ILO) has made its first formal commitment to increased action against drug and alcohol problems in "working and social life."

At its 73rd session, the General Conference of the ILO, the only organization in the United Nations system to give equal voice to governments, employers, and workers, adopted its first-ever resolution dealing with alcohol and other drugs.

Behrouz Shahandeh, ILO's vocational rehabilitation branch, says the adoption of the resolution means the organization "will have to take concrete steps to expand activities in the field of rehabilitation and social re-integration of alcohol and drug dependent people."

Shahandeh: consensus

One focus will be on "ways and means to assist workplaces to prevent and reduce problems associated with alcohol and other drug abuse." In the process, contact and collaboration among governments and employers' and workers' organizations will be enhanced, he said.

"The ILO is the only tripartite organization within the UN system that brings together, on an equal footing, governments, employers, and workers.

"It's not government delegates sitting in Geneva deciding for workers. The employers and the workers are also there developing consensus," he told **The Journal.**

The lengthy resolution allows that drug and alcohol abuse and their consequences:

- continue to raise problems in the workplace and to undermine the health and welfare of individuals and their families;
- are a contributing factor in accidents and pose a general threat to the working environment; and,
- increase absenteeism and decrease productivity, and thus result in escalating costs of enormous magnitude to industry, the economy, and society at large.

It stresses drug and alcohol abuse should be regarded in the same light as other health and social problems and says the ILO can contribute to formulating and executing programs to help member countries develop responses to problems in the workplace and countermeasures against problems in the field of vocational rehabilitation and social reintegration.

Meanwhile, the Vocational Rehabilitation Branch has developed a kit, including an audio-visual presentation called *Responses to Drug and Alcohol Problems in the Workplace.* (ILO Publications, ILO, CH-1211 Geneva 22, Switzerland.)

Alcohol counselling centre folds

CHRISTCHURCH, NZ — The Alcohol Counselling Centre, founded here by Dr Bill Black in 1979 to offer a problem-centred rather than disease-centred approach to alcoholism, has closed.

In addition to traditional, abstinence-oriented treatment services, the centre provided a controlled drinking program for about 20% of clients who were non-dependent drinkers, most of whom were less than 30 years of age.

At the centre's closing, Dr Black, also a Canterbury University psychologist here, said he believed some people misunderstood the concept.

"At no stage did we advocate that people who are dependent on alcohol should drink, or that anyone who had quit drinking should start again. But, there was always that suspicion, which some people still have, that we were teaching alcoholics to drink," Dr Black said in an interview.

The Alcohol Counselling Centre also provided a practical training forum for psychologists in the alcohol field. Most of the 45 psychologists trained here are still working in the addictions field.

The centre, established with funds from New Zealand's Alcoholic Liquor Advisory Council, saw 180 clients in its first year, and 480 in its last.

Jellinek award for 1987 goes to Norway's Skog

LAUSANNE — Ole-Jørgen Skog is this year's recipient of the Jellinek Memorial Award for outstanding contributions to the field of alcohol studies.

Dr Skog, PhD, a scientist with the National Institute for Alcohol Research, Oslo, Norway, was the first to recognize the problems and limitations of the Lederman theory which postulates a mathematical relationship between the mean level of alcohol consumption in a population and the prevalence of heavy use.

"Rather than simply criticizing this significant body of work, (Dr Skog) conducted a major theoretical re-specification and effectively transformed it . . . to a major theory on the etiology of alcoholism," cited Jellinek Memorial Fund president, H. David Archibald.

Jellinek

The 1987 award was presented at the 33rd International Institute on the Prevention and Treatment of Alcoholism here.

The Committee to recommend the 1988 Jellinek Memorial Award candidate is chaired by James Rankin, MD, head of medicine, Clinical Institute, Addiction Research Foundation, and professor of preventive medicine and biostatistics and medicine, University of Toronto. The category for next year is biological/medical (clinical).

INSIDE OUT

A letter to an old friend

You do not know it, but I have been paying attention to you lately.

Yes, I realize we have only talked to each other twice in the last few years.

And it's a fact we had so little to say: How have you been? Fine. What are you doing? Oh, nothing exciting. What about you? Well, I'm doing fine.

There was nothing there for either of us, just the usual fare of edgy people appearing to be in a purposeful hurry in a frantic city. You hardly looked in my eyes, really. I had the feeling you were glad you had legitimate excuses to run off.

But I've seen you two other times, too.

You were in a hardware store more than a year ago. You looked to be in quite sad shape. You had sunglasses on; it was dreary and cold and wintry outside. You quickly left. I was the guy looking at you from the lighting section, in case you're interested.

The other time I saw you was very recently. You were crossing the street; it was raining and dark outside, and you had on sunglasses again, and there was no way you couldn't have seen me. You walked right past. I guessed you'd perhaps decided in an instant that you couldn't, didn't want to, stop and chat meaninglessly for a moment.

You looked even sadder: you were unkempt, you weren't walking straight, and I suddenly was astonished at how much you'd changed for the worse since I'd first met you a decade ago, when we had a mutual friend.

You were attractive then; you had a fine, fine laugh, you were outgoing and lively, you had plans and energy and a straightforward optimism that dismissed complexities with a smiling shrug.

There are more people paying attention to you than you know . . .

But, our mutual friend has been telling me about you. She thinks you're going to die, soon, and although your hair is now gray you're only 40 years old.

You have become a hermit, she tells me. Your only forays now to the outside world are to the liquor store.

You don't work anymore. You're in a complete retreat on all fronts; you, who are so intelligent; you, who used to embrace it all so lustily.

You don't see men at all, haven't for years, she tells me. It's not because you're angry, it's not because you don't want to — our friend says you have phoned her in the devastating dead of night to whisper to her how much you'd like to love someone again, how you need someone to hold you.

You won't, she tells me, even go to visit her. She has to come to you. She doesn't want to do that anymore: it's too sad, you're too out of it. You can hardly see her after a few hours, yes, because your tears engulf you and you, with your truly simple life now, just can't deal with how many complexities there are now. And she is your only friend.

Of course she's told you you're addicted. She's told you over and over. Of course, you've told her, you have to stop, soon, you know that, but months and months go by, and you get worse and worse.

Our friend has even thought seriously of dragging you to a detox centre, but she can't, not yet anyway.

Your brother is an alcoholic too. That didn't mean a hell of a lot to you before — you could always binge together if you needed some company — but now he's stopped, stopped cold, and he's telling you to stop too. You don't want to hear him say those things, do you? So he doesn't come around anymore either.

So there you are, in your apartment, and the money's running out fast, and I see myself, when I think of you now, me a few years ago, and sure, I'd love to be a white knight coming to your rescue, but I am like your brother now, aren't I? I don't fit in with your lifestyle, and our friend — who'd go all the way to the wall for you — doesn't fit in now, either, does she?

And we know the pain you're in, and I know why you would like to keep on avoiding me because you know exactly what I would tell you if you gave me the chance, which you won't.

But listen: if you think you've gotten rid of all of us now, if you think the coast is clear, you're wrong. Because there are more people paying attention to you than you know, and when you finally fall, and we know you will, you're going to be awfully amazed to see how little a hermit you really are. And maybe, we are praying, you'll see that your lifestyle, as it is now, is so sadly unnecessary.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

NEWS AND COMMENT

Synthetic opiates a growing problem in Ireland

Heroin shortage, improper prescribing are blamed

By Karen Birchard

DUBLIN — Addiction to synthetic opiates is a growing problem in Ireland.

It was the first country to report addiction to diconal, a powerful painkiller usually administered to those with terminal cancer; the problem first appeared four years ago.

Now health and law enforcement officials here are concerned about increases in addiction to a range of synthetic opiates. In addition, the black market trade in synthetics is a problem.

Authorities say there has been a marked increase in the abuse of these drugs in the past few months because of the shortage of heroin on the street.

The national drug treatment centre, Jervis Street Hospital, Dublin, says the increase is significant.

Ireland, which has a population of less than four million, has more than 4,000 heroin addicts.

Drug experts say the real problem is one of irresponsible prescribing of the synthetic opiates by physicians. The prescriptions are filled by pharmacists without question because they are legal. The tablets end up on the black market, selling for hundreds of times their retail value.

For example, one tablet of diconal retails for around 70 cents, but brings at least $20 on the black market.

"The profit margin is very high so it's no less expensive a habit than heroin," says a spokesman for one Dublin anti-drug committee.

Synthetic opiates are crushed into powder, made into a solution, and then injected.

Health officials are therefore worried that the intravenous drug users are increasing their risk of AIDS, already high among Irish heroin users.

In Irish drug abuse centres, Physeptone (methadone hydrochloride) is given in liquid form, addicts are made to drink it in the presence of the nurse or doctor, and are given a full range of tests.

Patrick Deasy, Irish Pharmaceutical Association, says two years ago his society and the Medical Council drew up a set of guidelines because they could foresee a major problem as addicts began turning to general practitioners (GPs) for prescriptions.

"The guidelines suggest GPs only treat addicts from their local practice areas and that they contact local pharmacies to ensure necessary stocks for particular patients are available," said Dr Deasy.

One of the drugs being abused, temgesic (buprenorphine), is not a controlled substance here, but there are proposals to tighten regulations.

Many drug experts argue GPs should not have the power to write a prescription for a controlled substance, and the pharmaceutical association recommends only specially licensed physicians be allowed to prescribe drugs such as diconal. The proposal has failed to get support from the medical profession.

Lottery sparks fears for 'addicted gamblers'

By Karen Birchard

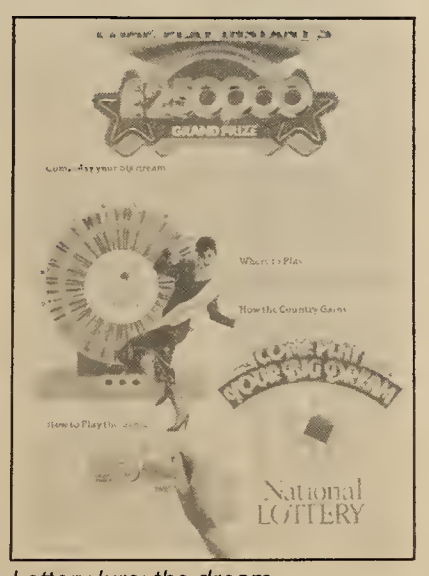
DUBLIN — The famous Irish Sweepstakes have been replaced here by a new national lottery that is succeeding beyond anyone's expectations.

And people who work with gambling 'addicts' are concerned.

Ticket agents have been swamped since last spring when lottery tickets were made available, and sales projected for a week are being surpassed in one day.

Newspaper headlines proclaim lottery fever has struck the country; those working with gamblers express fear the lottery will have a devastating effect on the poor.

The new Irish lottery is a combination of instant prizes and a monthly draw. The tickets are priced at £1 each (Cdn $2), and



Lottery lure: the dream

there have been reports of people collecting unemployment benefits or pensions and spending the money on instant lottery tickets sold in supermarkets, corner shops, pubs, and post offices.

Ticket agents have admitted they are witnessing scenes straight out of gaming arcades. People buy tickets "with the same fever people put money in the one-armed bandits," says one agent.

Priests who work with Gamblers Anonymous here have condemned the lottery. Father Peter McVerry accused the state of washing its hands of the social consequences and called the lottery itself "an exercise in delusion."

Senior and prominent politicians have joined in the criticism, warning of potential misery which could result.

Radio and television interviews with ticket buyers highlight critics' concerns. One woman, whose husband is unemployed, spent almost all her family allowance cheques on lottery tickets; if she won, she said, one instant money prize of £1,000 would be a big help with debts. After she lost, she was asked what she would do for money: "I'll see the money-lender."

Would she try again? The woman nodded; when the next cheque came in.

Similar stories are being repeated throughout the country; critics point out the addictive nature of instant-win tickets. Lottery organizers are criticized for allowing selected pubs to sell tickets, especially when it emerged in the press that most pubs with such licences are in areas of serious unemployment.

Tobacco: 'addictive killer'

Big, bald warnings

AUCKLAND, NZ — All tobacco packets in New Zealand will soon carry four health warnings, Health Minister Michael Bassett has announced.

The warnings must cover 20% of each main face of the packets.

They will say that smoking causes lung cancer, heart disease, and lung damage, and that it is an addictive killer.

Dr Bassett said he believes the public, particularly young, vulnerable experimental smokers, have a right to be told the truth about tobacco.

GILBERT

Children of alcoholics: II

Part 2 of 3

In September's column, I summarized evidence that children of alcoholics (COAs) have an increased risk of alcoholism, and that this increased risk may result from inherited differences in the responsiveness of the central nervous system to alcohol. Here and next month, I will consider the experience of being brought up in an alcoholic family and its impact on later adult behavior.

Does growing up with an alcoholic parent make alcoholism more likely? Last month I wrote that it does not. Adoption studies have shown that children whose biological parents were not alcoholic acquired no increased risk of alcoholism while being brought up by an alcoholic adoptive parent.

Discrepancies

These findings are difficult to reconcile with statements such as those of Claudia Black, PhD, quoted in **The Journal** in May, 1986, to the effect that: "Children in alcoholic families need help before they're nine years old. Otherwise, they may learn patterns that will lead them to become alcoholics themselves." And, "60% of alcoholics are raised in an alcoholic family setting."

They are also difficult to reconcile with my own conclusion last month that environmental factors seem stronger than genetic factors in the determination of alcoholism.

Dr Black's observations make intuitive sense. A child growing up with an alcoholic has a stressful early life, a model of alcohol's being used to reduce stress, and easy availability of the drug. However, the best evidence is that no more than about 30% of alcoholics were brought up in an alcoholic family setting, little more than what might be expected if there were no environmental effect at all.

Three points can be made about the discrepancy:

- The adoption studies deserve a closer look. Perhaps alcoholic adoptive parents are unusual enough that generalization from them is inappropriate. Adoption agencies go to pains to disqualify potential parents who are or might become alcoholic. The few that do may be adept at hiding their drinking and its effects even from their adopted children. Also, at least one adoption study has shown that alcoholism in the adoptive home is a factor in later alcoholism.
- Some estimates of early exposure to alcoholism are based on data provided by alcoholics themselves, who may exaggerate their experiences.
- The evidence may be confusing because experience of parental alcoholism could both contribute to later alcohol abuse and inoculate a child against it, according to circumstances.

The current great interest in the alcoholic family should lead to resolution of these disparate conclusions about the causes of alcohol abuse.

The burgeoning interest in families and alcohol has been well documented in **The Journal**, notably in a four-page supplement on coverage of the subject at the 1984 annual convention of the American Psychological Association in Toronto (**The Journal**, October, 1984).

The Addiction Research Foundation's work on the subject dates from the earliest days of the foundation. It includes the publication of staffer Margaret Cork's seminal book *The Forgotten Children* in 1969.

Concern is not so much with the propensity of these grown-up children toward alcohol abuse, as with damage to their personalities

Concern with the grown-up children of alcoholics, among both therapists and the victims themselves, is more recent. The concern is not so much with the propensity of these grown-up children toward alcohol abuse as with damage to their personalities. National associations of adult children of alcoholics have been founded in the United States and Canada. Self-help support groups have been formed in major cities: there are at least six in the Toronto area and a clearinghouse for exchanging information about them (telephone 416-360-0097).

Superficial contact with this movement has led me to ask two questions: why are its leaders and participants overwhelmingly women? Does the experience of growing up with an alcoholic leave a legacy of damage distinct enough to justify separate treatment or even treatment at all? Answers to the second question will have to wait until next month.

My impression that the movement is mostly female will likely be sustained by proper examination. One reason for the preponderance was touched on last month: daughters of severe alcoholics may inherit a propensity to be ill rather than to be alcoholic, and they find no solace from facilities for alcoholics.

Relationships

Another contributing factor may be the legacy of an imperfect relationship with an alcoholic parent, mostly the father. If the experience of a father is more important for a daughter than for a son, daughters of alcoholics may be more inclined to form self-help groups to resolve their difficulties in sustaining relationships.

Even with recent changes in parenting practices, women remain the primary caregivers in families. They are thus generally more disposed to be concerned about the quality of relationships between parents and children. Much of parenting involves comparisons with the parent's childhood. Comparisons can arouse uncomfortable memories that impel sharing and mutual understanding.

Women, in any case, are less reticent in seeking help than men, who can be more restrained by pride and reputation.

By Richard Gilbert

WOMEN

Treatment needs of elderly called 'desperate'

By Paul Szabo

DENVER — Older women will soon make up a major proportion of the female alcoholic population and pose a treatment challenge, speakers here at the 1st National Conference on Women's Issues predict.

"One pocket of people whom I think are in desperate need of treatment and much better understanding is the elderly population," said Jan Johnson, chairperson, women's commission. Alcohol and Drug Problems Association of North America, which organized the conference.

She said this is going to be primarily a women's issue because of the trend toward women living longer and outliving men.

"Retirement communities today are a place to drink," said Patricia Ann Pape, president, Pape & Associates, Wheaton, Illinois, noting drinking and playing cards are acceptable behaviors in such communities.

Ms Pape said denial is high among this older population (**The Journal**, February, 1986). "It's hard to call a nice grandma an alcoholic."

These women are often molded in the traditional, female hidden-drinking pattern, she said, and their problems develop later in life as their drinking slowly progresses.

The motivating factor to get these women into some form of treatment is a willingness by families to become involved rather than denying the problem.

Fern Asma, MD, director, occupational medicine, Parkside Medical Services, Denver, said her concern is "what are we going to do about the elderly, as a treatment issue."

With the concurrent growth in the number of patients with Alzheimer's disease, she said, "it is going to be very easy for physicians to find loss of memory, abstract thinking, slurring speech, and, eventually, brain atrophy, which are the symptoms that you find with Alzheimer's disease. They are also the symptoms for alcohol brain syndrome."

While Alzheimer's is a progressive disease, she said, alcohol brain syndrome is treatable and, therefore, must be accurately diagnosed by physicians.

Golobitsh

Retirement: physicians must distinguish alcoholism from Alzheimer's

HOWELL

As Epictetus might have said

Are you not cramped for room? Have you not to bathe with discomfort? Are you not drenched when it rains? Have you not to endure the clamour and shouting and such annoyances as these? Well, I suppose you set all this over against the splendour of the spectacle, and bear it patiently?"

So said the stoic philosopher Epictetus of Phrygia, commenting on the games at Olympia in the first century AD. Ironically, things haven't changed much 19 centuries later. A person wishing to attend the modern Olympiad in Calgary and/or Seoul is, more likely than not, going to end up cramped for room in some overpriced motel far from the action and is going to have to endure more than his fair share of clamor and shouting just to get tickets to the prime events. (All the more so in Calgary, where, it appears, the good tickets have already gone to friends of the organizers; and all the more so in Seoul, where, if present trends continue, the annoyances will include tear gas and rubber bullets.)

"You would fain be victor at the Olympic games, you say. . . . You must live by rule, submit to diet, abstain from dainty meats, exercise your body perforce at stated hours, in heat or in cold; drink no cold water, nor, it may be, wine. In a word, you must surrender yourself wholly to your trainer, as though to a physician."

This was the advice that Epictetus had for prospective Olympic athletes in the first century AD. What would Epictetus think of the modern Olympic games, and what kind of advice would he have for modern athletes? Bearing in mind that Epictetus was a stoic philosopher who advocated that wisdom was to be found in the acceptance of things as they are, and in submission to divine will; and bearing in mind that the god of the modern Olympiad is Mammon (the personification of riches and greed), perhaps Epictetus the stoic might wish to augment the *Golden Sayings of Epictetus* in this manner:

If a man take substances that increase his prowess and his manly bulk, he should triumph on the Olympic field. But perforce, he should accept the attendant shrinking of his privy parts with equanimity.

Surrender yourself wholly to your trainer. And if, perchance, he should advise the consumption of illicit substances to improve performance on the field, contemplate well and truly where lies your interest. If your interest be in obtaining a suitably lucrative contract to endorse dainty meats and other sundry items after the conclusion of the Olympiad, govern yourself accordingly.

If you have assumed a character beyond your strength, avoid the random testing.

Betimes a young Olympian has come to me and said: "Master, the days of my youth have past and my adult life begins: how should I order my temporal affairs?" And I have responded to such entreaties thus: "He that hath no musical instruction is a child in Music; he that hath no letters is a child in Learning; he that is untaught is a child in Life. In other words, if you are thinking of turning professional, it would behoove you to get a good tax accountant, a good lawyer, and a good agent."

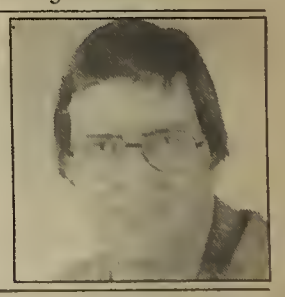
There are those that advocate the eating of Mandrake root to still the beating heart such that the aim of the javelin be more true. The stoic says, what profit a man to use Mandrake root in this endeavor when the leaves of the Foxglove plant are more efficacious in this regard?

If a Woman take substances that make her like a man in size and strength and body habitus, then woe be the lot of those that go against her on the playing fields of Olympia. She will triumph over All. And enjoy an increased procreative drive as well. That's something to think about.

What profiteth a man to win the decathalon, the pentathalon, the biathalon, ere he flunk the urine test?

Is it Vulgar, when he has left the field, for an Olympian of renown to lend his name to the merchants of the agora? Is it Moral for such a person to encourage the consumption of dainty meats and other things of frivolous nature? The answer to such questions lies in a man's own heart, but a cash advance and a just share of the residuals make the answer less problematic than it might otherwise be.

Acceptance of your limitations is no virtue: augmentation of your virtues is no vice. Just don't get caught.



By Wayne Howell

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REVIEWS

New Books

by Margy Chan*

This is a report of the British Medical Association (BMA) public affairs division, on the association's campaign to end all tobacco advertising and promotion in Great Britain. It contains lessons for campaigners so that other groups and individuals can join the campaign.

"In this book, the BMA presents the main arguments in the tobacco debate, as well as a review of the evidence of how tobacco advertising works directly against the principles of health promotion and undermines the credibility of government health education campaigns."

John Wiley & Sons, Chichester, W Sussex, England. 1986. 192p. ISBN 0-471-90937.

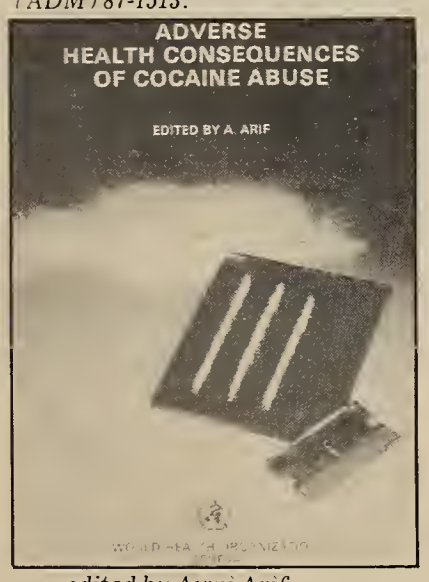
Acquired Immune Deficiency Syndrome and Chemical Dependency

This is a report of the symposium sponsored by the American Medical Society on Alcoholism and Other Drug Dependencies and the United States National Council on Alcoholism held in 1986. It summarizes papers presented and the discussions which followed.

The book covers presentations on the nature of AIDS, the link between substance abuse and AIDS, barriers to treatment of substance abuse in populations at risk, the effects of alcohol on the immune system, educational campaigns to curb the spread of AIDS, and clinical, psychosocial, and psychiatric issues in dealing with AIDS patients and the AIDS epidemic.

It was the first US national symposium on AIDS and chemical dependency.

US Department of Health and Human Services; Public Health Service; Alcohol, Drug Abuse and Mental Health Administration; National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland. 1987. 75p. DHHS publication no. (ADM) 87-1513.



. . . edited by Awni Arif

This is a succinct review of the cocaine problem which has reached epidemic proportions in areas of North and South America, Europe, and certain countries in Southeast Asia. These countries are experiencing public health and social problems associated with cocaine abuse.

This book is published as part of a World Health Organization project on Adverse Health Consequences of Cocaine and Coca-paste Smoking. It examines existing knowledge of the problem, its adverse effects on health, and reviews current approaches to treatment and prevention. It concludes with an overview of areas where research is needed.

This 41-page booklet will provide a useful summary for drug-abuse authorities and rehabilitation workers.

World Health Organization, Geneva, Switzerland, 1987. 41p. ISBN 924-156107-6. $10.19.

The Flower of Paradise: The Institutionalized Use of the Drug Qat in North Yemen

. . . John G. Kennedy

Qat (khat) is a stimulant drug used by a majority of people in North Yemen, as well as by many other populations in the area around the Red Sea. Since this substance is so interwoven into the fabric of society and culture, this book is very much about the history and the economic and social life of Yemen.

This study offers a different perspective on drug use and its effects in a country where the regular use of this substance has existed for several hundred years.

The book provides a very thorough study of qat (khat); its botany, chemistry, and pharmacology, the health effects of its use, and the question of addiction.

D. Reidel Publishing, Dordrecht, Holland. 1987. 268 p. ISBN 1-55608-012-3. $22.

Books received

Staying Clean: Living Without Drugs — Garden City, Minnesota. Hazeldon, 1987. 65p. ISBN 0-89486-447-5. A guide to the Twelve Steps of Narcotics Anonymous.

ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

White Lady

Number: 805.
Subject heading: Cocaine; employee assistance programs (EAPs).
Time: 15 min.
Synopsis: Many people use cocaine; some experience physical and mental health problems. Users describe the seductive effects of the drug and how it dominates their lives. EAPs can help workers who are experiencing problems with cocaine. A case study illustrates how an EAP can facilitate the rehabilitation of a good worker.
General evaluation: Fair to good (3.5). The statistics at the beginning of the film are out of date and do not add to the film's EAP message.
Recommended use: The film could be used with EAP committees.

The Medical Aspects of Mind Altering Drugs

Number: 782.
Subject heading: Drugs: pharmacology.
Time: 30 min.
Synopsis: Max Schneider discusses mind-altering drugs: alcohol, marijuana, sedative hypnotics, narcotics, inhalants, psychedelics, and stimulants, using animation and graphics.
General evaluation: Very poor to poor (1.8). Scientifically inaccurate, this film is a poor teaching aid.
Recommended use: None.

Monday Night, Tuesday Morning

Number: 804.
Subject heading: Health and safety; hangover.
Time: 15 min.
Synopsis: While watching the Monday night football game on television, Harry and an older coworker drink heavily. As they drive to work the next morning, Harry says he's very tired and his friend complains of stomach pain. Harry has difficulty parking his car. Both men insist they will be fine once they are on the job. During the morning, neither man works well and Harry's friend seems to be feeling worse; he traps and mangles his hand in a machine. Harry cannot understand: his father, who drank a great deal, always seemed fine the next day.
General evaluation: Good to very good (4.9). The film is realistic, a good length, and well acted. Hangover symptoms are clearly portrayed. The film could lead to good discussion about the problems of hangovers on the job.
Recommended use: With a resource person, this film could benefit general audiences, health and safety committees, and employee assistance programs.

The Drug Knot

Number: 798.
Subject heading: Drugs and youth; public relations.
Time: 37 min.
Synopsis: While practising for a band audition, a high school student smokes a joint with his girlfriend. A teacher discovers them and makes them leave. At the audition, the band leader rejects the student saying drug use interferes with his playing. At a school assembly, David Toma speaks about drug use. The student is disruptive and is ejected; his girlfriend is moved by the presentation. Mr Toma holds a parents' session to which the girl brings her boyfriend's mother; Mr Toma assures them they will get help for Doug. The boy comes home to find his brother, who has used some cocaine, floating face down in the swimming pool.
General evaluation: Poor (2.1). The film promotes David Toma and his style of intervention, but contains minimal information and is of little educational value.
Recommended use: This film could be used by those contemplating a David Toma presentation.

Smokeless Tobacco: The Sean Marsee Story

Number: 807.
Subject heading: Smokeless tobacco.
Time: 15 min.
Synopsis: Sean Marsee is on his highschool track team. One afternoon after practice he uses smokeless tobacco and offers some to his buddies. One turns him down saying his girlfriend does not like the habit. Sean claims smokeless tobacco is better than regular cigarettes and that since professional athletes use it, it must be all right. At home, Sean's mother is angry that he and his younger brother are using smokeless tobacco and warns them not to use it in the house. Two years later, Sean is getting ready to compete in a very important track meet. For two months, he has been concerned about a sore on his tongue; when he tells his mother about it, they go to a doctor who urges Sean to have a biopsy immediately. Sean decides to wait two weeks until after graduation. Three months later, Sean dies of mouth cancer.
General evaluation: Fair (3.4). Sean's story is realistically presented, but the film is slow moving. The film could lead to discussion about the use of smokeless tobacco and its consequences. General broadcast is recommended.
Recommended use: With a resource person, the film could be used with teens and their parents.

Choices and Consequences

Number: 793.
Subject heading: Drugs and youth; treatment rehabilitation.
Time: 28 min.
Synopsis: Eric, Stewart, and Izzie sneak out of their houses one night. They smoke a little pot; Stewart decides to break into a house to steal money to get more. On the way home, they are stopped by the police for impaired driving. A police officer tells Eric's dad what happened and recommends a school group for Eric and the others. All three go to the first session, but Stewart soon stalks out. Izzie manages to stop her drug use after the first level of intervention. Eric, however, must continue to the second level. Stewart does nothing about his problem until there is a confrontation.
General evaluation: Very poor to poor (1.8). It is a training film on a specific type of intervention. However, little is said about how to implement the intervention, its rationale, or its effectiveness.
Recommended use: The film could be used with health professionals.

Career opportunities

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Current Trends in Addictions —Oct 3, Oct 22, Windsor, Ontario. Information: Iona College, United Church of Canada, Affiliate of the University of Windsor, 208 Sunset Ave, Windsor, ON N9B 3A7.

Public Forum: Mixed Reactions — Seniors, Alcohol, and Drugs — Oct 8, Toronto, Ontario. Information: Donna Heughan, special events, Addiction Research Foundation, 33 Russell St. Toronto, ON M5S 2S1.

AIDS: A Holistic Response — Oct 15-16, Edmonton, Alberta; Oct 22-23, Montreal, Quebec: Nov 12-13, Toronto, Ontario; Nov 19-20, Halifax, Nova Scotia. Information: Freda Fraser, director of communications, Catholic Health Association of Canada, 1247 Kilborn, Ottawa, ON K1H 6K9.

Different Groups/Different Needs — Oct 17, Toronto, Ontario. Information: M. Hughes, inservice education, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Counselling Communication Skills Course — Oct 19-23, and July 11-15, 1988, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

12th Annual Canadian Intravenous Nurses Association Convention — Oct 22-23, Scarborough, Ontario. Information: Pam Smith, CINA, 4433 Sheppard Ave E #200, Agincourt, ON M1S 1V3.

Aging with Excellence: Social, Mental, Physical, and Spiritual Fitness — Oct 22-25, Calgary, Alberta. Information: Canadian Association on Gerontology, 1080-167 Lombard Ave. Winnipeg, Manitoba R3B 0V3.

Respiratory Care Update: Planning for a Smoke-free Future —Oct 23, Toronto, Ontario. Information: The Lung Association, 573 King St E, Ste 201, Toronto, ON M5A 1M5.

Input 87: 7th Biennial Educational Symposium on Employee Assistance Programs in the Workplace — Oct 25-28, Ottawa, Ontario. Information: Input 87, conference and seminar services, 205 Humber College Blvd, Etobicoke, ON M9W 5L7.

Addiction Intervention Association: Minimizing Barriers to Accessing Treatment — Oct 26, Sudbury, Ontario. Information: Kathryn Irwin-Seguin, Box 1360, Stn B, Sudbury, ON P3E 5K4.

Critical Risk/Quality Care: Adolescents in Secure Settings — Oct 27-30, Toronto, Ontario. Information: Roberta Roberts, Thistletown Regional Centre, 51 Panorama Crt, Rexdale, ON M9V 4L8.

Productivity 87: Employee Assistance as a Benefit and Productivity Tool — Oct 28-29, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4RS.

2nd Annual Ruth Cooperstock Memorial Lecture: Nuclear Addiction — Oct 29, Toronto, Ontario. Information: Patricia Erickson, head, drug policy research, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Drug Education Coordinating Council 1987 Conference, Drug Abuse: Epidemic or Smokescreen — Oct 29-30, Toronto, Ontario. Information: Larry Hershfield, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8.

9th Annual Conference of Substance Abuse Librarians (SALIS) — Nov 3-6, Edmonton, Alberta. Information: Bette Reimer, conference chair, Alberta Alcohol and Drug Abuse Commission library, 10909 Jasper Ave, Edmonton, AB T5J 3M9; or Ginny Rolett, SALIS chair, Project Cork Resource Center, Dartmouth Medical School, Hanover, New Hampshire 03756.

Children of Alcoholics: Turning the Corner — Nov 5, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Making a Difference: Managing Workplace Pressures for Health Professionals — Nov 9-10, Scarborough, Ontario. Information: Jill Birch, program manager, conference and seminar services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7

Tomorrow's Youth Today — Nov 11-13, Collingwood, Ontario. Information: Lise Labrecque, conference coordinator, 74 Hurontario St, Unit 1, Collingwood, ON L9Y 2L8.

Public Forum: Drug Use and AIDS — Nov 12, Toronto, Ontario. Information: Addiction Research Foundation, special events, 33 Russell St, Toronto, ON M5S 2S1.

Canadian Conference on AIDS Education — Nov 12-13, Cornwall, Ontario. Information: John Darbyshire, Eastern Ontario Health Unit, 1000 Pitt St, Cornwall, ON K6J 3S5.

Connections 88 — Feb 8-10, 1988, Saskatoon, Saskachewan. Information: Saskatchewan Health Research Board. Ste 5, 3002 Louise St, Saskatoon, SK S7J 3L8.

Canadian Society of Hospital Pharmacists — Feb 1-5, 1988, Toronto, Ontario. Information: Barbara Cole, Canadian Society of Hospital Pharmacists, 123 Edward St, Ste 603, Toronto, ON M5G 1E2.

United States

Physicians of Tomorrow: A Colloquium to Advance Medical Education in Alcohol and Other Drug Dependencies — Oct 6-7, Chicago, Illinois. Information: Joseph S. Dolan, program officer, The J.M. Foundation, 60 E 42nd St, Stc 1651, New York, NY 10165.

A Day with David Smith on Cocaine and Alcohol — Oct 9, Chicago, Illinois. Information: Myra Nichols or Cathy Moynihan, Interventions, Professionals for Counscling and Education, 1234 S Michigan Ave, Chicago, IL 60605.

New Directions in Chemical Dependency — Oct 17, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

115th Annual Meeting American Public Health Association — Oct 18-22, New Orleans, Louisiana. Information: APHA, 1015 15th St, NW, Washington, DC 20005.

Freedom 87: Geisinger National Conference on Addiction — Oct 28-Nov 1, Philadelphia, Pennsylvania. Information: Alan D. Hulsman, Freedom 87, c/o Marworth, Waverly, PA

Family Therapy Works: 45th AAMFT Annual Conference — Oct 29-Nov 1, Chicago, Illinois. Information: American Association for Marriage and Family Therapy, 1717 K St NW, Ste 407, Washington, DC 20006.

Alcohol Policy Conference — Community Applications to the Prevention of Alcohol Problems — Oct 31-Nov 4, Charleston, South Carolina. Information: Jim Neal or John Bond, South Carolina Commission on Alcohol and Drug Abuse, 3700 Forest Dr, Columbia, SC 29204.

2nd Annual Teen Institute Training Conference — Nov 1-4, Charleston, South Carolina. Information: John King, National Association of Teen Institutes, 8790 Manchester, St Louis, Missouri 63144.

Chemically Dependent Women in the Workplace: Identification and Intervention — Nov 4, New York, New York. Information: Education training dept, International Center for the Disabled, 340 E 24th St, New York, NY, 10010.

AIDS and Chemical Dependency: Multidisciplinary Approaches — Nov 7-8, San Francisco, California. Information: Mim Landry, Haight-Ashbury education group, 409 Clayton St, San Francisco, CA 94117.

Association for Medical Education and Research in Substance Abuse Annual Meeting — Nov 10-13, Rockville, Maryland. Information: AMERSA conference coordinator, Brown University Center for Alcohol and Addiction Studies, Box G, Providence, Rhode Island 02912.

Second Western Regional Conference — Nov 11-13, San Francisco, California. Information: National Association of Student Assistance Programs and Professionals, Box 3148, Oakton, Virginia 22124.

Association for the Advancement of Behavior Therapy Annual Meeting — Nov 12-15, Boston, Massachusetts. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

Southeastern Conference on Alcohol and Drugs 1987 — Dec 2-6, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease division, Box 209, Ste 701, Macon, GA 31298.

Abroad

Sucht 87 — Nov 2-5, Osnabruck, Federal Republic of Germany. Information: Deutsche Haupstelle gegen die Suchtgefahren, E. Gocke/DHS, Postfach 1369, D-4700 Hamm 1, Fed Rep Germany.

International Symposium on Alcoholism and Drug Addictions Among Seafarers — Nov 4-6, Vigo, Spain. Information: Xose Teixeiro, coordinator scientifico, Casa del Mar/Orillamar, 51, E-36202 Vigo (Pontevedra), Spain.

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Japan Convention Services Inc, Nippon Press Center Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.

Alcoholism and Other Dependencies — Nov 22-25, Warsaw, Poland. Information: C. Godwod-Sikorska, Institute of Psychiatry and Neurology, Sobieskiego 1-9, PL-02-957 Warsaw, Poland.

9th International Conference of the Non-Governmental Organizations for the Prevention of Drug and Substance Abuse — Nov 23-27, Hong Kong. Information: Conference secretary, 9th NGO conference, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

International Conference on Alcohol and Industry — Dec 3-5, Medellin, Colombia. Information: SURGIR and ICAA, Apdo. Acreo 10199, Medellin, Colombia.

Heather Graham

Workforce shifts, information swamp EAPs

SEATTLE — Much of the education, literature, and standard wisdom about employee assistance programs (EAPs) is geared to the past, when a blue-collar, male, unskilled labor force dominated industry.

Today, as skilled women match their male counterparts in numbers at work, and as union membership dwindles, EAPs are being newly challenged to provide help to a workforce in transition. One of the problems is information overload, says Keith McClellan, PhD. He is a former occupational expert for the United States National Institute on Alcohol Abuse and Alcoholism and director, Health Interventions, for the Council on Health Costs, Inc, Charlotte, North Carolina.

Dr McClellan, in an address to the North American Congress on EAPs here, said fundamental changes in society since 1940 require like changes in employee assistance. And he suggests some "points to consider" in looking at EAPs.

His comments, condensed for **The Journal** *by Contributing Editor* **Karin Maltby**, *follow.*

"In 1940, 75% of the workforce in the United States were male, 50% were unskilled, most were blue-collar, only one in 22 had attended college at all, and large industrial plants could have as many as 3,000 employees on a single assembly line.

The heavy concentration of employees made it possible for the trade-union movement to form and organize rapidly — in 1940, 40% of the workforce belonged to labor unions.

Production quotas were set at places of work by time-management studies, and you could tell the level of seniority of managers by the size of their desks.

Most women were out of the workforce by the time they were 22 years old, divorce was rare, and people were 'rooted' to the same homes for many years.

In 1940, recovering alcoholics — members of Alcoholics Anonymous (AA) — became 'two-hatters,' as they joined companies to help identify alcoholic employees. It was an appropriate move because the principle form of job impairment was alcoholism. It was the beginning of the EAP movement.

In 1985, for the first time, there were as many women as men at work. Now, virtually everyone must have some skill. If you don't, in this new era, you become a bypassed worker. Jobs are filled by what people have in their heads and not what they can do with their hands.

That creates a problem for EAPs; it's no longer possible to measure job performance with a stop-watch. Because skill is difficult to measure, it's difficult to use impaired job performance as the primary indicator of impairment. How do you know when a teacher is not doing her job? A lot of that measurement is subjective — it has to do with the values you have and the values held by the teacher. The same is true of all occupations.

By 1985, the major employers were schools, hospitals, information centres, and institutions. While a corporation may still have thousands of employees, they are scattered in small clusters across the country. For example, one of the largest employers in the US is Domino Pizza, with 160,000 workers across the country. They drive more miles in a single day than the Chicago transit authority.

Fewer and fewer workers are organized. It's silly to say that union participation is an essential part of an EAP, when in 83% of cases, there's no union to be represented.

There have also been dramatic changes in family life. Today, divorce is far more common than it was in 1940, and we are getting many different types of family structures. The point is, we're experiencing different types of problems and these changes need to be reflected in the kinds of services we provide in the EAP movement.

'It's no longer possible to measure job performance with a stop-watch'

Industrial and office automation are creating new problems as well. If your job is interacting with a video display terminal, much of the social interaction you find pleasurable about work is gone. You're going to find social isolation and technostress.

Twenty years ago, information was power; today, we have so much information we don't know what to do with it. There are hundreds of publications in the EAP field. We don't know what to believe and what not to believe. Information is not the problem. It's making sense of surplus information and a shortage of knowledge of how to use it.

Decentralization of economic activities is leading to an inevitable loss of employee benefits. If you don't have collective bargaining skill, what forces the employer to give you the benefits?

There is also an erosion of health-care benefits, which will affect the way we deliver EAP services. It's not simply a matter of determining a person's problem, but of getting the resources to solve it. And, if employees don't have health benefits, they're out of luck.

Chronic health-care problems such as mental illness, alcoholism, diabetes . . . mean that our clients with these problems will inevitably be affected by health-care rationing. We're going to have to think of new ways of reaching people whom we haven't been able to reach before.

'Health promotion has kept well people well'

New technologies, like computers, have created great opportunities not only for good, but also for bad. There are now ways to steal railroad box cars by computer.

People electronically transfer millions of dollars, and they steal it without going to the bank. There is no way of stopping these transfers without an invasion of privacy for the employee.

Drug testing has many implications, including loss of privacy. We now have the technology to identify people who are using drugs, and that is not going to go away. If you had billions of dollars tied up in an oil rig and a handful of employees working on that rig, would you drug test? I would.

But there is even more frightening technology: a single drop of blood can determine genetic predisposition to organic disorders. If we test to screen out those who are health risks, they become unemployable and uninsurable.

In the early 1970s, EAPs determined that if they focused only on alcohol, they would be missing people who had other problems. But, when they reluctantly changed their focus from alcohol to other types of work impairment, more problems were generated, necessitating differential diagnoses. When you start that, you need technical skills not required before.

With this broad-brush or comprehensive EAP concept came the consortium, with efforts to reach not just the large but the small employers through external and internal programs.

In the early 1980s, we thought, 'We're always dealing with a dead soldier. We're always dealing with the problems after they've been generated. Why don't we start doing preventive work?'

But, there is a problem with preventive work. Education is not prevention, although many people assume so. You can educate someone so he becomes an enlightened drug user. But, it doesn't change behavior. Health promotion hasn't been really successful at reaching at-risk populations. It has kept well people well.

You can't achieve early intervention if work impairment is a criterion. Work impairment, in every case, is a late-stage indicator of problems. Behavior change is the key.

To achieve successful early intervention, focus on assistance rather than penalties and on problem avoidance not simply problem management: focus on problems people are willing to solve, and use that motivation to reach other areas.

Some other points to consider:

- Since education does not yield behavior change, employee assistance staff can provide the missing link of behavior motivation. If we don't provide that missing link, then we don't have any purpose.
- Occupational alcoholism programming is becoming inappropriate in most workplaces. About five years ago, I tried to get ALMACA (Association of Labor-Management Administrators and Consultants on Alcoholism) to change their name (to include other drugs). They wouldn't do it then and they still won't. They are fighting the battle of years ago.
- Health care costs for chronic health problems have moved the emphasis to early intervention. Improved technology has made many problems manageable that weren't before. But, it has also driven costs up.
- Inpatient treatment for alcohol, mental health, and other drug problems has become more widespread, expensive, and relatively inefficient, because it's essentially a single-episode treatment for a chronic health problem.
- Holistic health care has replaced fragmented approaches. It's not good enough now simply to dry a drunk out. We need to deal with family problems. We need to deal with children of alcoholics, with other lifestyle issues that inevitably grow out of dysfunction.

Finally, a lot of counselling by EAPs is self-centred, and these counselling techniques reflect society. The attitude is to take care of the self first and not the family. This too needs to be reassessed. Individual self-interest, separated from the continuity of the family, religion, and moral tradition has created a society in which the traditional concept of friendship has been changed.

The pendulum tends to go both directions, and I think counselling techniques that only emphasize self-interest need to be examined.

AA couldn't have started in the 1970s. It had to start in the 1930s when everybody was going through the Depression. Nobody had anything, so they depended on each other. That tradition made it a great movement."

THE BACK PAGE

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INSIDE

Drop supply/demand barriers or strategy fails — Archibald

By Joan Hollobon

WINNIPEG — Encouragement, warnings, and reminders marked a forthright keynote address by H. David Archibald to the National Forum on Drug Awareness here:

- encouragement to delegates to work together to make a success of Canada's national drug strategy — if it fails, "we can forget the issue for another decade;"
- warnings that such endeavors can give "full flight" to egos and self-interest; and,
- reminders "we have a common goal . . . our goal is, at the very least, to try to help people who are being hurt, directly or indirectly by alcohol and drugs. At best, our goal is to try to protect people — especially the young — from becoming harmed by alcohol and drugs in the future."

Mr Archibald, founder of Ontario's Addiction Research Foundation (ARF), president of the International Council on Alcohol and Addictions, an international consultant to United Nations' organizations, and senior adviser to the federal government in developing the national strategy, is respected worldwide in the addictions field; his influence was evident throughout the intensive two-day forum here sponsored by Health and Welfare Canada.

Traditionally, he said, the two main avenues to contain drug problems have been demand reduction — research, treatment, prevention — and supply reduction — regulation, development programs in drug-producing countries, border control, and law enforcement. (He gave alcohol prohibition as a classic example of this strategy.)

In Canada, most of the knowledge, experience, and expertise in demand reduction rests in provincial centres, including non-governmental organizations, because provinces and territories have been working on such programs much longer than the federal government.

Supply side

Until now, national governments have concentrated almost exclusively on the supply side of the equation. Almost all human and financial resources, nationally and internationally, have been allocated to police action against drug traffickers. "But this model hasn't worked," Mr Archibald said.

Among those in Canada who now recognize this are the Royal Canadian Mounted Police and other police forces across the country, who are now encouraging drug squad officers, numbering more than 1,000, to get involved in public education.

"I think it is terribly important for each member of this powerful group to become a partner with community action groups. . . we should welcome them as part of our community scene," Mr Archibald said.

Everyone, in demand- and in supply-reduction, must stretch beyond traditional roles to work together at local, provincial, national, and international levels: no unique model will succeed.

"In the face of the smooth-running, multi-national (drug) industry, I am sorry to note that our field of addictions is disorganized and riddled with territoriality.

"Researchers cannot, or sometimes will not, communicate with community workers.

Turf protection

"Federal and provincial officials compete for status. We behave as a team on which each person wants to be, and strives to be, the captain.

"We in demand-reduction programs — research, treatment, prevention — scoff at the police and vice versa. The fundamental operating philosophy is 'protect your

(See Archibald, p3)

Drug Awareness
A NATIONAL FORUM

. . . US targets demand too

By Harvey McConnell

ST LOUIS — No amount of law enforcement will stop drugs from entering the United States, so the goal must be to remove people's need for drugs, not to remove drugs from the country.

Experiences with the police in Washington, customs officials on the Mexican border, and the Coast Guard in the Gulf of Mexico, have convinced Ian Macdonald, MD, director, White House Office on Drug Abuse Policy. "While the supply side is important, we aren't going to win the war that way."

A shift in focus would be to the user and non-user of drugs, he told the annual conference here of the Alcohol and Drug Problems Association of North America.

If one asks if education and prevention efforts have changed knowledge, attitudes, and behavior, he said, "for all three, there is a dramatic 'Yes,' any way you want to measure it." A majority of people know cocaine is dangerous, marijuana is not harmless, and alcohol and tobacco use increase risks.

Dr Macdonald said a start should also be made on holding the user more responsible for his or her behavior. Those who treat alcoholics, for example, hear myriad reasons why people drink.

While the reasons may be true, "recovery cannot occur as long as they don't focus on the fact these chemicals, for them, produce loss of control and change in behavior."

There are some who say fear of punishment does not work; that is simply not true, said Dr Macdonald. Studies have shown 40% of adults polled do not or have not tried illicit drugs for fear of discovery, the same fear, Dr Macdonald added, that always stopped him from trying marijuana in the 1970s when it was chic among his contemporaries.

Macdonald: off fence

Fear of punishment does not mean sending young people to jail. A number of US states, for example, have recently passed laws that minors caught in possession of alcohol or other drugs automatically lose their driving licence for a year.

Dr Macdonald declared Missouri's current, 'Mo Says No' campaign makes it clear only one position can be taken about alcohol and drug use among young people: it is wrong.

Dr Macdonald said Nancy Reagan is often criticized for her 'Just Say No' message and its simplicity. It is not an attempt to solve all the problems, "but what it does more than anything is represent a society that is willing to get off the fence. Either you take an active, hostile position, or you give tacit approval; there is no middle ground."

Epp: cost sharing

Funding for local projects a priority

WINNIPEG — New grants for community groups with innovative addiction prevention and treatment ideas were announced here by Jake Epp, minister of Health and Welfare, at the National Forum on Drug Awareness.

Funding guidelines for community-based projects, developed in cooperation with provincial and territorial addictions agencies, will be available early in November, he said.

"For the balance of this year, we have allocated $500,000 for community action, with two-thirds allocated to prevention projects and one-third to treatment. Next year, that budget will be increased to $1.8 million, and it will reach a peak of $4.5 million in the fourth year of a five-year program."

Mr Epp said the funding is designed to encourage "the type of activity you are discussing during this national forum: the active involvement of individuals, families, and volunteer and community groups to identify and prevent drug abuse and to treat drug abusers."

Priority will be given to voluntary, non-governmental, non-profit organizations.

While prevention should be the ultimate goal, the minister said he is "fully committed to federal support of the treatment of victims of alcohol and other drug abuse for as long as this need exists."

Currently, about $23 million a year is distributed to the provinces and territories for treatment under the Vocational Rehabilitation of Disabled Persons and the Canada Assistance Plan.

"We are currently reviewing a cost-sharing plan with the provinces and territories whereby my department will contribute an additional $10 million in 1988/89 and $20 million over each of the following three years.

"It will support expanded treatment and rehabilitation services which reach those who are currently under-served and provide for innovative approaches in working with chemically dependent individuals."

Sponsored by Health and Welfare Canada, the forum brought together people from across Canada to discuss planning and implementation of drug awareness programs.

"Networking" was a popular buzz-word, as people from communities as far apart as Coppermine and Iqualuit in the Arctic and Vancouver and Montreal, shared experiences and made new contacts.

Youth Minister Jean Charest told the forum he considers the federal government's long-term, mul-

(See Partnerships, p3)

NEWS

Briefly . . .

Flying high

OTTAWA — Canadian birds may be singing a different tune following a federal drug regulation that allows bird-seed to contain non-viable cannabis seed. *The Toronto Star* reports the seeds must be treated so they won't grow marijuana. Sale of untreated seed, even for birds, is in violation of the Narcotic Control Act.

Drug games

BIG RAPIDS, Michigan — A Monopoly-style board game designed to reach young people when traditional counselling methods fail is being promoted in the United States. "The game simulates the events and feelings you would experience on the streets as a user of crack, cocaine, and other addictive substances," says Tom Rundquist, a developer of the game and a former drug rehabilitation counsellor. Players draw cards that may send them to hospital with drug overdoses, take 50% of their earnings for drug buys, or land them in jail.

Primrose plan

GUELPH — Evening primrose is being touted as the "logical" replacement for tobacco crops in Southwestern Ontario's tobacco belt, reports *Smoking or health*, the newsletter of the Canadian Council on Smoking and Health. The flower, which grows along the province's roadsides, is suited to the climate and soil conditions and, says the newsletter, can bring revenues comparable to the once-lucrative tobacco. The oil is Vitamin E-rich.

Workplace ban

BUDAPEST — Hungary has banned drinking in workplaces and some public places. Sales and consumption in offices and factories have been prohibited, and violators will face fines of about $200 — more than the average monthly income, reports *The Globe*, a magazine published by the International Organization of Good Templars.

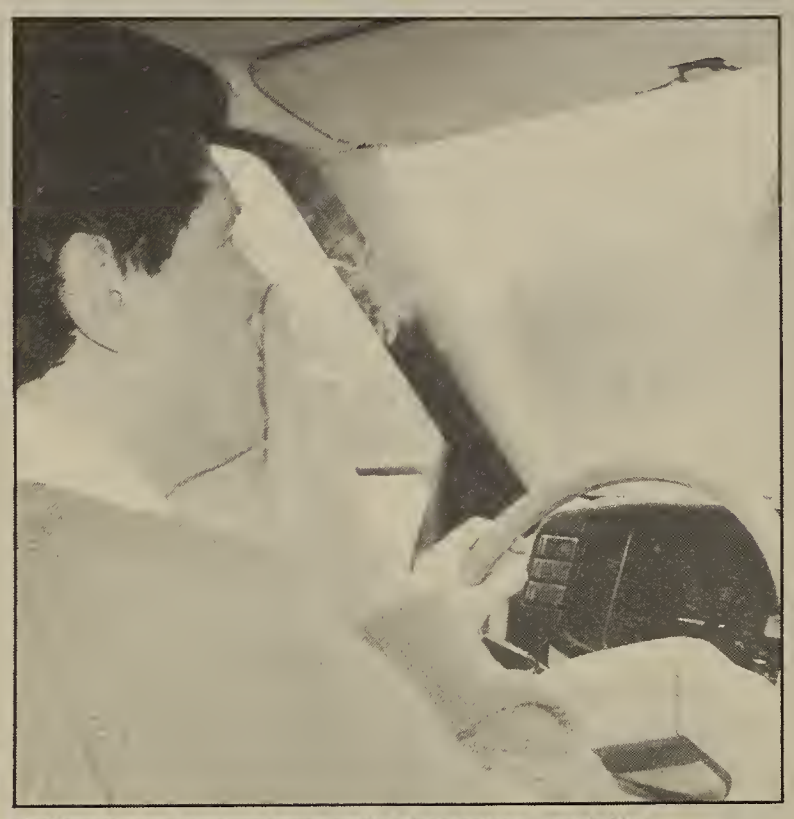
Sea 'weed'

RIO DE JANEIRO — Beachcombers here have been finding more than just shells in recent weeks, as thousands of unlabelled cans filled with compressed marijuana have been washing up on the beach. *The Toronto Star* reports police suspect a Panamanian-registered yacht that broke down off the Brazilian coast en route from Australia to the United States.

Cocaine/hepatitis

SYRACUSE, NY — More than half the 75 victims of an outbreak here of infectious hepatitis (hepatitis A) are cocaine users. Officials are alarmed, says *The Drug Abuse Report*, because until now, intravenous (IV) drug users, including users of IV cocaine, have typically contracted hepatitis B. And, officials are unsure of the source of the virus. Researchers speculate trace amounts may be on the users' hands or other surfaces the users contact, and passed through hand-shaking; or, the cocaine itself may be infected with the virus.

Clearing the air — in smoke-filled cars



Puffing driver: carbon monoxide, distractions, visibility

By Betty Lou Lee

WINNIPEG — Smoking may be a factor in traffic accidents — even if the driver doesn't smoke.

The carbon monoxide level in a car with one cigarette burning and the windows closed can reduce visual acuity by 20% in half an hour. Slowed reaction times and impaired time discrimination can also occur with subacute carbon monoxide toxicity, says Rob Brison, MD, department of surgery, Queen's University, Kingston, Ontario.

Other driving risk factors that may be associated with smoking include distractions caused by lighting, extinguishing, or dropping cigarettes, and more risk-taking behavior by smokers.

While working in Seattle, Dr Brison compared more than 500 male drivers aged 30 to 39 years who had at least one motor vehicle crash (MVC) over a two-year period with those who had no accidents.

Each group filled out mailed questionnaires about their use of alcohol, tobacco, and seat-belts; miles driven per year, and accident histories.

"Smokers who were at fault for their accidents had a 50% increase in risk of MVC over non-smokers," he concluded.

One problem in assigning cause and effect is that "alcoholics are more likely to be smokers than the general population, and drinking drivers are more likely to have accidents," Dr Brison noted. "Our results suggest there is an association between cigarette smoking and auto accidents and one that is independent of alcohol use."

Other factors could be eye irritation from smoke, coughing spells, and reduced visibility through smoke deposits on windshield interiors — a factor especially risky at night.

At the annual meeting of the Royal College of Physicians and Surgeons of Canada, Dr Brison told The Journal more direct studies of the risks involved in smoking in cars are needed for firm conclusions.

"These results would support a move by auto insurers to provide reduced rates for auto insurance to non-smokers. However, the evidence is not yet sufficient to propose legislation that would ban smoking in automobiles," he told the meeting.

Prevention, intervention, discipline

Guide helps schools build drug policy

By Joan Hollobon

TORONTO — A guide to assist school boards concerned about student use of alcohol and other drugs has been prepared by Ontario's Addiction Research Foundation.

The guide addresses prevention, early intervention, and disciplinary procedures and provides a model policy.

Accompanying it is a detailed appendix examining the legal rights, powers, and obligations of educators as laid out in common law and various statutes, including the Education Act, the Trespass to Property Act, and the Criminal Code.

It also examines the impact of the Charter of Rights and Freedoms through a court case in which a student unsuccessfully appealed a conviction of possession of a narcotic on the grounds his rights under the Charter had been violated.

The guide is designed as a starting point for boards, which can adapt it to local needs.

"The need to develop a comprehensive alcohol and drug policy cannot be easily dismissed by boards, nor should they be satisfied with ill-considered or token efforts," says the introduction to the guide.

"Throughout Ontario, they (boards) are recognizing that a serious problem exists and that a considered and comprehensive response is the only responsible course of action."

The guide suggests educators should appreciate the general patterns of student consumption, in order to assess priorities. Many trustees and board employees, for example, consider cannabis and other illicit drugs the most serious threat to students; the facts show the drugs used most are alcohol and tobacco. Taken as a whole, alcohol and drug use are more harmful to Ontario students than any other "health-related" behavior, the guide says.

Four kinds of problems — health, social, personal, and legal — befall students who use alcohol and other drugs.

Students: running the risk

Not only do students run the risk of experiencing any or all of these problems, but also school boards risk being perceived as condoning illegal consumption, the guide suggests.

A model policy provides "an illustrative example" which boards can use "as a template, introducing modifications wherever their perspective differs, and retaining the text where there is concurrence."

The appendix, *The Legal Rights, Powers and Obligations of Educators*, says it is important for educators to realize that separate rights, powers, and obligations exist under the Education Act, the Trespass to Property Act, and the Criminal Code. Authority for a specific action lacking under one Act may be granted under one of the others.

UK anti-AIDS ads blunt but on target: defender

LONDON — A new series of advertisements warning intravenous drug users of the dangers of spreading the HIV virus with the slogan: "It only takes one prick to give you AIDS," has been launched by the British government.

Secretary of State for Social Services John Moore has brushed aside complaints by some members of his Conservative party that the slogan could offend some people.

"We have to concern ourselves with using the most effective message for those we are trying to contact."

Strategy agenda is 'very Canadian'

By Anne MacLennan

WINNIPEG — The national drug strategy and program — *Action on Drug Abuse/Contre les drogues* — "is not an agenda that can be implemented by governments alone," says Joan Marshman, PhD.

It is one that "should engage all of us as parents, as professionals, as volunteers, as Canadians," she told the National Drug Awareness Forum here.

"It's fair to say we're setting out to change Canada's social environment in respect to alcohol and other drugs. It's our society, and it's our challenge."

Dr Marshman, president of Ontario's Addiction Research Foundation, is also chairman of the federal/provincial advisory committee working with the federal government to implement the strategy.

Reviewing the strategy and program from her personal perspective as chairman, she said the agenda is both "very Canadian" and "very ambitious."

Unlike those of some other countries, the Canadian approach "recognizes the importance of addressing both alcohol and other drugs, and it recognizes the importance of both treatment and prevention.

"It is Canadian because, in these and in many other respects, it reflects the needs identified to the government of Canada by provincial and territorial governments and by professionals and volunteers in various community systems."

She reminded the approximately 160 delegates from across Canada at the forum that "though it may be new to you," the committee she chairs — which includes a representative of each provincial or territorial agency or government department responsible for addictions affairs — has existed in varying forms since the early 1970s.

It is one of several advisory committees in the health field — covering mental, community, and occupational health, as well as other areas. They were set up to ensure each jurisdiction a mechanism for contributing to national health policy through advice to the conference of deputy ministers of health and, through them, to the ministers.

"It is through this mechanism that the provincial and territorial governments have a working partnership with the government of Canada . . . in the development and implementation of the *Action on Drug Abuse* program."

Focusing on the demand-reduction side of the national program, she said the advisory committee has set up working groups for each of five key areas identified in the strategy: public awareness and information, community action, education and training, research and data needs, and cost-sharing (**The Journal**, June).

The groups have developed some short-term plans for the deputy ministers' conference and have begun to shape longer-term plans.

For the longer term, Dr Marshman anticipates some changes across the board, among them:

- an increasingly wide range of public awareness and information vehicles, including newsletters, newspapers and magazines, radio and television programs, videotapes, promotion tied to sporting and entertainment events, telephone information services, and hands-on exhibits and displays;
- education and training for health and social service personnel focusing on clinical assessment of young drug users, as a basis for selecting appropriate treatments; parent education materials and services; and, funding assistance for professionals and volunteers for specialized training;
- community-based program funding soon in a modest way, but increasing in future for a total of $15.6 million over five years, which should yield some innovative and cost-effective programs which can be adapted in other parts of the country (see page 1);
- expanded research, which will lead to a "better understanding of many important issues" and a better basis for designing treatment and prevention approaches; and,
- development of a national information system on drug use to serve the ongoing information needs of governments, the addictions community, the broader health and social services sector, law enforcement professionals, and voluntary organizations involved.

Marshman: 'It's fair to say we're setting out to change Canada's social environment'

Archibald advises workers, hear what others are saying

(from page 1)

own turf.' That may be good for a person's ego, but it doesn't do much for our communities, for the people we're trying to help, or for our country."

He said the exciting part of the planning process, described in bureaucratic terms as coordination, collaboration, and communication, "is people — people of many backgrounds, learning together and working — struggling when necessary — toward a common goal."

This is the essence of an effective program whether it is local, national, or international, Mr Archibald said.

"Find out what has been the experience in other communities, and build on it. . . . Ask others and *listen* — some people are so full of what they are doing, they talk, talk, talk. It is important to be enthusiastic, but we must take time to listen. Communication occurs only when one hears what others are saying," Mr Archibald said.

He said the federal government showed vision in recognizing that any program, to be successful, must be comprehensive and balanced, must recognize the roles of demand and supply reduction, and must be coordinated among federal and provincial governments and local communities.

A colleague abroad, after observing a national campaign in his own country, told Mr Archibald a national strategy should be treated "with extreme caution . . . the main winners in our campaign have been able to give full flight to their egos and self-interest; the real workers, the victims, and the community generally, just go battling on."

While this concern should be kept in mind — "like it or not, there will be egos and self-interest in full flight here in Canada as well" — Mr Archibald said he is confident Canada can do a better job.

"We are off to a better start, and Canadian human resources are better than in many countries."

Program development difficulties in the addictions field are compounded by the complexity of the phenomenon, powerful economic considerations, different culturally shaped concepts and behaviors, and formidable ideological confusion, he said.

Many conflicting statements are advanced about drugs and alcohol that complicate the situation but can also be useful in developing essential dialogue to reach a common understanding and to agree on a course of action.

Archibald: 'There will be egos and self-interest in full flight'

Drug awareness plans depend on cooperation

WINNIPEG — Action by local communities is the key to the effectiveness and the survival of drug awareness programs, says Marvin Burke, executive director of the Nova Scotia Commission on Drug Dependency (NSCDD).

Drug/Addiction Awareness Week November 15-21

In a paper to the National Drug Awareness Forum here, Mr Burke outlined various ways to make contact with others who have the energy, time, ideas, and commitment to work on drug awareness projects, from knocking on doors to contacting social service and health agencies and health-care professionals in the community.

(Mr Burke's speech was read in his absence by Kevin MacPherson of the NSCDD).

Also important are self-help organizations, such as Alcoholics Anonymous, Al-Anon, Alateen, and Narcotics Anonymous, whose members work every day to maintain their own health and to help others do the same, he said.

Essential for community groups is what Mr Burke describes as "co-ownership;" when people feel they have a stake in a program, drive and enthusiasm follow.

Mr Burke said the central office of the NSCDD began Drug Awareness Week but quickly turned over special projects to towns and villages across Nova Scotia. The provincial media, too, became actively involved.

"The level of activity was tremendous . . . because the commission realized the importance of the local community," he said.

Partnership — co-ownership — between the NSCDD and the communities has continued. Drug Awareness Week is now a year-long program. Once the annual special week is over, the program is evaluated and the planning begun for the following year.

Mr Burke said the concept of Drug Awareness Week began in Nova Scotia, soon spread to New Brunswick, and, within a year, all four Atlantic provinces were working together. They have continued to do so and to share ideas and materials.

Partnerships basic to success

(from page 1)

ti-dimensional approach a realistic strategy to combat alcohol and other drug dependency, which are a particular threat to the young.

A balanced approach is essential for an effective strategy, said Mr Charest.

Mr Epp: "We cannot beat drug abuse by working alone, by applying only one approach, or by assuming that all Canadians have the knowledge or understanding to act in their own best interests."

He expressed particular concern about adolescent drug use, including solvent abuse in the inner cities and in northern communities. Two television advertisements directed to parents will be shown on the French and English language networks beginning this month as part of a media campaign that will also include transit and mall poster advertising.

Partnership, a basic principle of the strategy, must include like-minded groups and individuals, not ignoring the private sector "as an agent for positive social change." Hilroy Incorporated, the major Canadian manufacturer of school supplies, Safeway supermarkets, and the International Council of Shopping Malls have all committed themselves to promoting public awareness of drug abuse issues, he said.

Although provincial governments pioneered the concept of drug awareness week, Mr Epp said the federal government joins their "long-standing initiative," with the first National Drug Awareness Week, November 15 to 21.

Next month:
More from the National Forum

NEWS

RESEARCH UPDATE

Input on nicotine-laced gum

While nicotine gum can be useful in helping smokers quit in specialized clinics, it's of questionable value when prescribed by general practitioners. Researchers at Mount Sinai School of Medicine, City University of New York, statistically analyzed all published randomized, controlled trials (14) that have evaluated the efficacy of nicotine gum in stopping patients' smoking. The analysis shows in specialized smoking cessation clinics, the success rate of nicotine gum at one year is 23%, significantly higher than the 13% reported with placebo gum. In contrast, in general medical practices, the success rate for the nicotine gum was 9% at one year, compared with 5% for control subjects who did not use gum. There was variation in the protocols of the trials analyzed, but the researchers say pooling the data is possible and provides evidence that proper use of nicotine gum in specialized clinics for a short period of time will increase the rate of stopping patients' smoking. But, they conclude: "We believe that there is not yet convincing evidence to justify widespread use of the gum in general medical practices." They say the difference in results could be attributed to the fact that people who attend smoking cessation clinics are likely to be more motivated to quit.

The Lancet, July 4, 1987, no.8549:27-30.

Athletes cough up passive smoking data

Even young, healthy athletes can show the effects of passive smoking, New York researchers have shown. A study evaluated the exposure to passive smoking in a group of 12- to 17-year-old, New York high school athletes who were non-smokers. Researchers from a variety of medical centres in New York assessed the passive-smoke exposure and any pulmonary symptoms of 193 subjects and conducted tests to measure pulmonary function. Almost 75% of the total group were exposed to passive smoking; the study found that athletes with a history of cough and who showed abnormal pulmonary function were four times more likely to have been exposed to passive smoking. "Our group of overall healthy, athletic teenagers — a group we would least expect to show manifestations from passive smoking — showed clear evidence of its effects," the study concludes. The researchers suggest pediatricians should consider passive smoking if they see an adolescent patient with a chronic cough or decreasing pulmonary function.

Pediatrics, July, 1987, v.80:32-35.

Australian research on women and cirrhosis

Australian researchers have shown that women who drink more than 40 grams of alcohol daily have a significantly increased risk of developing cirrhosis of the liver. Four researchers from Sydney evaluated 41 women with a first diagnosis of cirrhosis admitted to the eight main hospitals in the Sydney-area over a 20-month period. The women had no evidence of non-alcohol related disease. Controls were selected from women admitted to the same hospitals who were not lifelong abstainers from alcohol but who were admitted for conditions not alcohol-related. All subjects were interviewed, and their level of alcohol consumption determined. The study found the risk of cirrhosis due to alcohol consumption significantly increased in women who consumed between 41 g and 60 g of alcohol daily, independent of nutrition, drug use, and medical history. The researchers note that while only 1% of the Australian female population consumes this quantity of alcohol daily, 90% of women identified with cirrhosis in the study did. Preventive measures aimed at the small group of women who drink at these levels could result in a substantial reduction in the incidence of alcohol-related cirrhosis in females, the study concludes.

British Medical Journal, July 11, 1987, v.295:80-82.

Respiratory tract damage from marijuana

Direct examination of the respiratory tract in heavy marijuana smokers reveals evidence of inflammation and other abnormal findings. In the first published report of a direct examination, researchers described using a flexible fiberoptic bronchoscope to evaluate systematically the gross and histopathologic features of the tracheobronchial tree in habitual, heavy (at least 10 joints weekly for at least five years) marijuana smokers between 25 and 45 years old, with or without concomitant tobacco use. The findings were compared with those from a group of age-matched smokers of tobacco alone, and non-smokers of similar age. Researchers from the department of medicine, University of California School of Medicine, Los Angeles, and the pathology department, Wayne State University, Michigan, said the examination revealed airway hyperemia (inflammation of the wall of the airway mucosa) and other visible abnormalities in virtually all of the smoking groups, with no significant findings in the non-smoking group. Subjects who smoked both marijuana and tobacco showed squamous metaplasia to a degree significantly higher than any of the other groups, and marijuana smokers had a higher degree of cellular disorganization. No relationship between lifetime marijuana use and histologic results was seen. Overall, the researchers say, the high prevalence of airway lesions in the relatively young group of heavy marijuana smokers is similar to that seen with older, long-term tobacco smokers and suggests a possible link, yet unproven, with bronchogenic cancer.

American Review of Respiratory Diseases, July, 1987, v.136:1-2 1-9.

Pat Rich

Double-doctoring cut dramatically by triple 'script control system

By Paul Szabo

CALGARY — A program designed to reduce prescription drug abuse in Alberta appears to be working, and officials in charge of licensing physicians are ecstatic.

In its first year, the triple prescription program (**The Journal**, May, 1986) has led to a 53% reduction in the number of narcotic drugs being prescribed, said Roy LeRiche, MD, registrar of the provincial college of physicians and surgeons.

In addition, he said, the number of patients 'doctor-shopping' for drugs has dropped to fewer than 1,000 from 3,000.

"It has been the greatest success story ever imagined," Dr LeRiche told the annual meeting of the Canadian Medical Association in Charlottetown. Doctors at the annual meeting of the Alberta College of Physicians and Surgeons here were given a detailed account of the program.

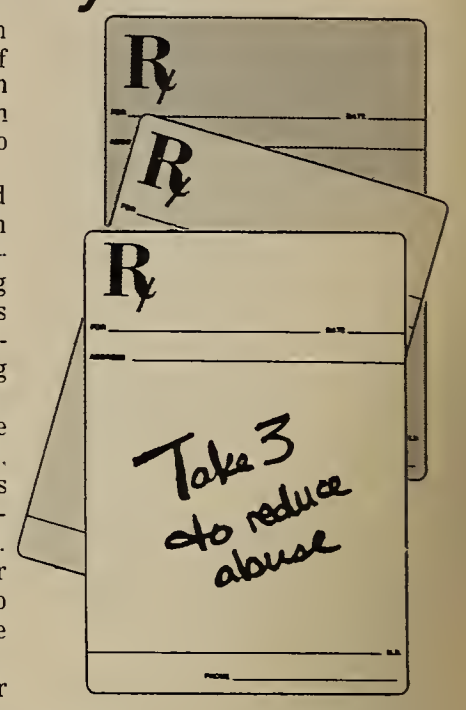
The triple prescription program aims at tracking prescriptions of certain drugs, such as Ritalin (methylphenidate) and Percodan (oxycodone), which are subject to abuse.

In addition to the doctor and pharmacist having prescription copies, a third is sent to the college, which monitors prescribing patterns and identifies patients who are double-doctoring or physicians who are improperly giving out the drugs.

At the Alberta meeting, college President Martin Atkinson, MD, said in the first year, 20 doctors were identified as prescribing inordinate numbers of the listed drugs. None was treating terminal cancer patients or had other reasons to prescribe such large quantities, he said.

"Some may just be very naive or cavalier in how they prescribe," he said. "Some of them are just stupid and get conned."

However, two of the physicians were also independently monitored and charged by the Royal Canadian Mounted Police. All of the doctors identified are being investigated further by the college.



Despite mammoth publicity

US cocaine use still rising

By Harvey McConnell

ST LOUIS — Cocaine dependence continues to escalate in the United States despite the mammoth publicity it has received in the past year.

Charles Schuster, PhD, director of the US National Institute on Drug Abuse (NIDA), said the latest quarterly report for the Drug Abuse Warning Network (DAWN) shows "the number of emergency-room mentions for cocaine exceeded that of alcohol and other drugs for the first time.

"This is not to say that the problems of cocaine are having more public health consequences than alcohol. I am simply saying they are clearly continuing to increase, despite our best efforts to publicize the dangers of cocaine."

Dr Schuster, speaking here at the annual conference of the Alcohol and Drug Problems Association of North America, later commented that the rise may be due to more people smoking rather than sniffing cocaine. Most emergency-room mentions are in the 20- to 40-year age group.

The only positive note is that

> ***'The only positive note is that the overall incidence in the 12- to 17-year age group is going down . . . a little.'***

"the overall incidence (of cocaine use) in the 12- to 17-year age group is going down, not much, but a little," Dr Schuster added.

"But, we are concerned because cocaine continues to be a tremendous public health problem, and it has affected a broad range of our society.

"Segments which are absolutely imperative for our future are having their lives adversely affected."

He said intravenous (IV) use of heroin is being discussed in relation to spread of the human immunodeficiency (HIV) virus, but pointed out the latest figures show between 25% and 30% of cocaine users take the drug intravenously.

Dr Schuster said NIDA is studying the methods to treat cocaine dependence.

"There are many private sector treatment groups out there who are espousing a variety of different approaches to the treatment of cocaine dependence, and, frankly, there is very little in the way of good treatment-outcome studies to justify the claim for effectiveness of these approaches.

"Therefore, it is incumbent on NIDA to evaluate these as quickly as possible so that we can determine, as quickly as possible, if they are as effective as some people say they are."

Turning to the problem of heroin abuse, Dr Schuster said the blithe comment that the US has "around 500,000 addicts," should be phrased, "Good God, we have 500,000 people dependent on heroin." The AIDS crisis adds new impetus to the search for ways to deal with this problem, he said.

The aim is to get more people into treatment; at the moment, only about 20% of addicts are in treatment.

Dr Schuster said many approaches are needed, including the use of buprenorphine (eg, Temgesic) and methadone. Buprenorphine "has a major impact on some patients" who will not take the antagonist naltrexone. The drug gives some of the subjective effects of heroin but then acts as an antagonist like naltrexone.

Dr Schuster said this year NIDA is funding the training of local teams in Chicago, New York, Philadelphia, Miami, and San Francisco to go out among IV drug users to try to get them into treatment — including methadone maintenance. NIDA hopes to fund work in another 15 cities next year, "so we can get the word out and get everyone into treatment that we can."

Treatment approaches for both cocaine and heroin are now being evaluated by four centres around the US.

Cirrhotic liver complication linked to brain-ammonia load

By Betty Lou Lee

WINNIPEG — Ammonia in the brain is probably the cause of hepatic encephalopathy that accompanies cirrhosis of the liver in alcoholics, a University of Montreal team has found in both human autopsy and animal studies.

Roger F. Butterworth, MD, associate professor of medicine, presented the findings at the annual meeting here of the Royal College of Physicians and Surgeons of Canada.

The production of ammonia in the gastro intestinal tract is part of the breakdown of protein, he told **The Journal**.

"Normally, this ammonia is removed by the liver, but with cirrhosis, this ability is compromised, and the ammonia gets across the blood-brain and cellular barriers."

In the early stages, hepatic encephalopathy causes confusion, personality changes, and changes in sleep patterns, Dr Butterworth said. It is steadily progressive to a stuporous state and, ultimately, deep coma. While the timing of the progression depends on the degree of liver damage, it can be speeded up by constipation and/or gastrointestinal bleeding.

Once in the brain, the ammonia appears to tie up or interfere with the neurotransmitters with which cells communicate with one another. There is some evidence it may deplete glutamate, an excitatory amino-acid, so that inhibitory neurotransmitters predominate, he said.

"In the last four or five years, our understanding of the neuronic action has grown by leaps and bounds," Dr Butterworth said.

Methods being tried by some clinicians to reduce the ammonia load include low-protein diets and substances to alter the pH in the gastro intestinal tract to reduce production of ammonia.

Hospitals fear addiction among anesthetists

Medical cocaine use drops

CHICAGO — Anesthetists' problems with cocaine have prompted many United States hospitals to stop using the drug, long a favorite anesthetic for nasal surgery.

That's the message given to otolaryngologists here for the annual meeting of the American Academy of Otolaryngology - Head and Neck Surgery. The conference was attended by more than 5,000 ear, nose, and throat surgeons.

"There are many centres around this country where cocaine is not permitted to be used by anesthesiologists. We just don't use it," said Mervyn Maze, MD, assistant professor of anesthesiology at Stanford University in California.

Dr Maze said the main reason is not the potential toxicity of the drug, but the "serious problem" of addiction among anesthetists.

With less and less cocaine used in anesthetic practice, Dr Maze said, physicians are turning to other vasoconstrictive drugs such as phenylephrine (eg, Neo-Synephrine) for use in surgery.

Other doctors on the anesthesia panel made it clear while cocaine has been used for decades in nasal surgery, the exact safe dosage of the drug has never been established.

David Fairbanks, MD, professor of otolaryngology, George Washington University, Washington, DC, called cocaine "probably the most valuable anesthetic ever developed." But, he added: "Despite cocaine's 100 years of serving the nasal surgeon, the maximum safe dose has never been established."

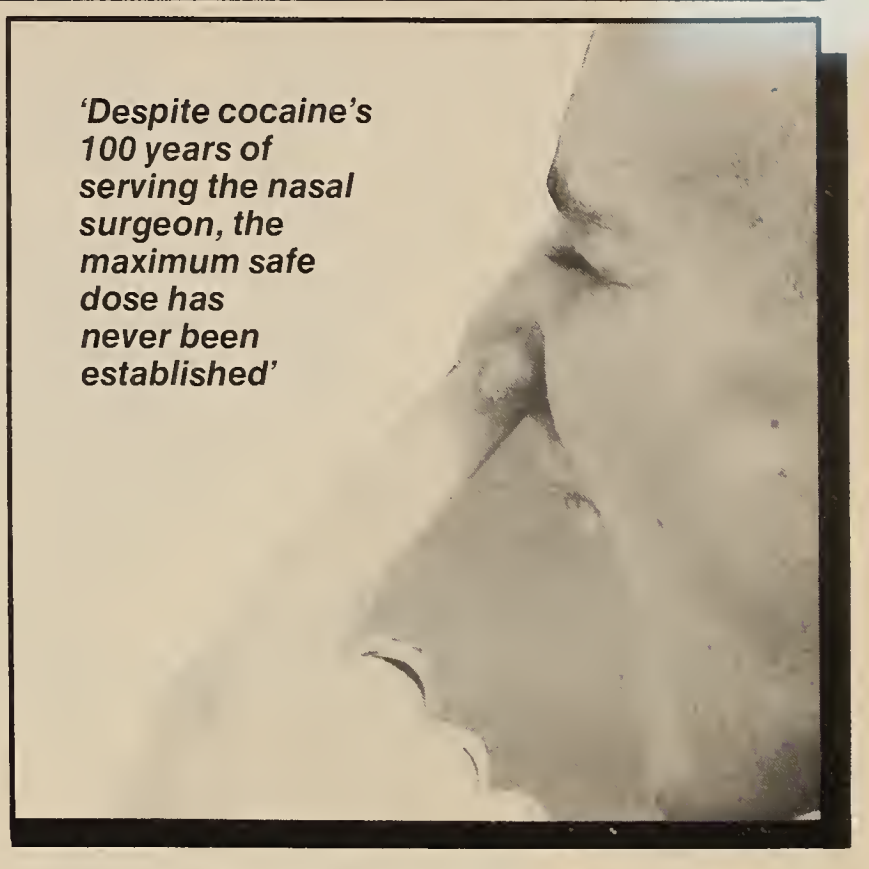
A decade-old survey of US otolaryngologists shows few surgical fatalities due to the drug, but Dr Fairbanks pointed out many occurred at "extremely and mysteriously low doses."

While doctors 100 years ago were aware of cocaine's dangers, he said, "tragically, we forgot."

Still, Dr Fairbanks maintained, in the medical setting, cocaine is a safe drug to use as long as precautionary measures are taken.

In contrast, Dr Maze said: "I think cocaine is a very dangerous drug. I can't think of a single virtue other than that it is a vasoconstrictor; I would decry the use of cocaine in our setting."

'Despite cocaine's 100 years of serving the nasal surgeon, the maximum safe dose has never been established'



GILBERT

Children of alcoholics: III

Part 3 of 3

Last month, I left unanswered the question as to whether the experience of growing up with an alcoholic leaves a legacy of damage distinct enough to justify separate treatment or even treatment at all. Here, I'll suggest that although the experience may be disabling for the child, the legacy of harm is small and overrated. I'll suggest too that involvement in one or another of the many therapy and self-help groups for adult children of alcoholics (ACOAs) may be counterproductive for the ACOAs and for society.

Clinicians report that children brought up in a family with an alcoholic experience one or more of the following:

- gross inconsistencies in parental affection, physical care, and discipline;
- physical deprivation caused by poverty or neglect;
- sexual and other physical abuse;
- chronic deception about drinking and its effects, within the family and toward the outside world;
- excessive responsibility for the family's problems, both real and imagined, and for maintaining the family; and,
- shame about some or all of the above.

Clinicians report too that as a result of these experiences, ACOAs tend to have the following traits: low self-esteem, excessive feelings of responsibility, difficulties reaching out, and depression. The United States National Association of Children of Alcoholics reports that, in addition, ACOAs tend to be afraid of authority figures, frightened by angry people and personal criticism, and terrified of abandonment. They seek and help victims, confuse love with pity, and feel guilt about self-assertion. They crave excitement.

Degree of exposure

Little formal work has been done on the relation between childhood experience of an alcoholic parent and adult disability. The only prospective longitudinal study I could find concluded that:

"*Degree of exposure to alcoholism in the childhood family environment was highly correlated in later life with increased alcohol use, alcoholism, time in jail, sociopathy, and death, but not with increased rates of unemployment, poor physical health, or measures of adult ego functioning. Most of the impairments observed occurred in those subjects who actually developed alcoholism.*" (W.R. Beardslee et al, *British Journal of Psychiatry*, 1986.)

This study, which compared 176 men who had grown up with an alcoholic parent with 230 men without such exposure, was itself flawed in that delinquent adolescents were excluded from both groups of subjects. Other studies have shown that delinquent adolescents frequently come from families with an alcoholic. Thus the generalizability of the results may be limited.

Nevertheless, the findings that ACOAs who do not become alcoholic are hardly different from others, and that even alcoholic ACOAs do not differ from controls on measures of ego functioning, should not be undervalued: they are the only solid pieces of evidence we have on the matter.

The propensity of ACOAs to alcoholism was discussed in the two previous columns. Additional evidence, found in many studies, is that ACOAs who become alcoholic tend to do so earlier and with greater severity than alcoholics who were not reared with an alcoholic. (See, for example, E.C. Penick et al, *Journal of Studies on Alcohol*, 1987.)

The proposition that all adults are war veterans encourages narcissism and acceptance of therapy as normal human discourse

Why ACOAs become more severely alcoholic may be partly genetic and partly a product of childhood learning about the customs and practices of alcohol use. However, the primary concern of therapy and self-help groups for ACOAs is not with incipient or actual alcohol abuse but with the personality disorders of the participants.

ACOAs often find their way to such groups after hearing or reading about the experience of children in an alcoholic family and experiencing what has been called a "startled shock of recognition." Alcoholism researcher Sharon Wegscheider-Cruse reported one woman as saying, "When my sister first showed me a pamphlet describing the family constellation, I was amazed. It was as eye-opening as my first awakening to feminism. All of a sudden, everything fell into place, and I understood why I behaved the way I did. I also knew I wasn't alone in that behavior." The process has some of the elements of religious conversion.

In their groups, ACOAs are encouraged to go through a process of recovery. In a 1985 book with the title, *Guide to Recovery*, Herbert Gravitz and Julie Bowden describe the process as having these stages:

- emergent awareness, in which ACOAs "begin to become aware of the psychological, physiological, and genetic vulnerabilities that they acquired as a result of being reared in a home where there is an alcoholic,"
- transformations, in which ACOAs "take the characteristics they developed to survive as children and discover how to use them to better suit the circumstances of their adult life,"
- integration, in which ACOAs "put together the various aspects of their own experience — mental, emotional, spiritual, and behavioral — (so that) they can respond to the environment in a more effective way and have a stronger sense of well-being,"
- genesis, in which ACOAs become aware of "a spiritual connection which unites us all in the sense of being one with the universe."

The therapeutic journeys undertaken by ACOAs in their groups are similar to the processes developed by Freud and other psychoanalysts for achieving emotional maturity through coming to terms with childhood experiences. Are the journeys necessary?

Gravitz and Bowden suggest that ACOAs need to experience recovery to enjoy life to the full, that ACOAs have been damaged by their childhoods in a way unlike others, that they are "survivors" who have stayed alive in a war zone and are like shell-shocked war veterans.

Shock of recognition

I tried hard to understand just how ACOAs are different from people not reared in alcoholic families, apart from their relation to alcohol. The reported salient traits — low self-esteem, etc — seem widely shared. The only clear difference is the "shock of recognition" phenomenon noted in many ACOAs when they learn about alcoholic families. But, this is little different from other kinds of sudden awareness about one's place in the world — as women, blacks, gays, and factory workers have experienced from time to time — and not obviously a basis for therapy.

The preface to the 1987 printing of *Guide to Recovery* (now titled *Recovery: A Guide for Adult Children of Alcoholics*) as much as reverses the book's position on the singularity of ACOAs:

"*. . . Children of alcoholics are but the visible tip of a much larger social iceberg which cast an invisible shadow over as much as 96% of the population (of the US). These are the other 'children of trauma.' Surviving their childhoods rather than experiencing them, these children of trauma have also had to surrender a part of themselves very early in life. Not knowing what hit them, and suffering a sourceless sense of pain in childhood, they perpetuate the denial and minimization which encase them in dysfunctional roles, rules and behaviors. . . .*

"*Over 200 million of us are denying our past. . . .*

"*Perhaps 230 million abused children of all ages in our country! All are children of trauma, the children of our time. . . .*

"*Without abandoning our commitment to the more than 30 million children of alcoholics, we would like to open our hearts to the other children of trauma, and acknowledge that they too have been hurt, and they too have a road map to recovery.*"

Destructive position

Gravitz and Bowden have thus arrived at the destructive position taken by the British psychiatrist R.D. Laing, most eloquently in his 1967 essay, *The Politics of Experience:*

"*From the moment of birth, when the stone-age baby confronts the 20th-century mother, the baby is subjected to these forces of violence, called love, as its mother and father have been, and their parents and their parents before them. These forces are mainly concerned with destroying most of its potentialities. This enterprise is on the whole successful. By the time the new human being is 15 or so, we are left with a being like ourselves. A half-crazed creature, more or less adjusted to a mad world. This is normality in the present age.*"

The position is destructive because its claim that all children are damaged fosters rejection of parents, parenting, and the family. The proposition that all adults are war veterans encourages narcissism and acceptance of therapy as normal human discourse. The view that society is sick is contemptuous of the achievements of human civilizations and the actual predicaments of people in society. If we took Gravitz, Bowden, and Laing literally, we would all be in therapy. No one would be minding the store.

*****

I showed the draft to my wife, a participant in ACOA groups, with some trepidation. She found the perspective intriguing and challenging, but could not agree with most of the conclusions. ACOA groups, she said, are an expression of the natural human urge to understand the world and one's place in it and to develop that understanding in the company of people with similar experiences. They provide a sense of belonging and a non-threatening setting where issues of personal significance can be raised.

By Richard Gilbert

LETTERS

Collaboration of professionals

New TJ board members

TORONTO — **The Journal** is pleased to announce the appointment of three new members to its Editorial Advisory Board.

Joining the Board this autumn are Ottawa lawyer Maureen McTeer, Toronto pediatrician Diane Sacks, and Chief Superintendent Rodney T. Stamler of the Royal Canadian Mounted Police (RCMP). Recently retired from the board are Lionel Solursh, MD, formerly of Toronto, now professor, Medical College of Georgia, Veterans Administration Medical Center, Augusta, Georgia, and Hugh Segal, president, Advance Planning Consultants, Toronto.

Ms McTeer is known across Canada as a lawyer, political activist, and author. Her second book, *Parliament: Canada's Democracy and How it Works*, was published in September. Ms McTeer is a member of the board of the Northern Alberta Children's Hospital Foundation, the Toronto Planned Parenthood Association, an honorary director of CARAL (Canadian Abortion Rights Action League), and a former member of the Board of Governors, University of Ottawa.

Dr Sacks is staff pediatrician, Substance Abuse Clinic, Adolescent Clinic, Hospital for Sick Children, Toronto; assistant professor of pediatrics, University of Toronto; and, in private practice. She is a member of the Canadian Pediatric Society committee on adolescents and the United States Society for Adolescent Medicine. She has served on many special boards and committees in Canada and the United States and has written extensively on teen pregnancy and sexually transmitted diseases and youth. Dr Sacks is also a member of the editorial board of the University of Toronto *Health News*.

McTeer

Sacks

Stamler

Chief Supt Stamler is director, Drug Enforcement Directorate, RCMP, and a noted authority in Canada and abroad on drug law. He has served the international community for several years as a member of Canada's delegation to the United Nations Commission on Narcotic Drugs and participated in a range of related international activities. He is currently playing a leading role in development of a new international convention aimed at reducing the profits of drug trafficking (**The Journal**, April).

Senator Lorna Marsden, chairman of **The Journal's** Editorial Board welcomed the new members: "We are very pleased to welcome these new members to the board, which is composed of an array of opinion-shapers in education, research, treatment, and media here and abroad.

"With a lawyer, a physician with particular interest in young people, and a senior law enforcement officer, the board mirrors the new spirit of cooperation in this field in Canada and the new national, and international, efforts to reduce harm caused by drugs through collaboration between people in both demand and supply reduction programs."

SADAC's northern program expanding

We were most pleased Harvey McConnell was able to come to our province and write extensively (August) about the programs and services available through the Saskatchewan Alcohol and Drug Abuse Commission (SADAC).

SADAC is excited about our new programming across the province and finds **The Journal** an excellent way to share our new initiatives with others across Canada.

However, we are concerned about some of Mr McConnell's impressions of northern Saskatchewan.

SADAC finds the progress being made in northern Saskatchewan very inspiring. The SADAC staff are there to work with the communities and do not hide from northern problems. The staff have grown to understand and help northern communities develop community commitment to reducing the detrimental effects of alcohol and drugs. SADAC staff have a commitment to change in the north.

Four new outpatient centres, a northern mini-course, addictions training for northern health and social workers, and an emphasis on working with the young people — including the summer youth camps — are all new, positive approaches SADAC uses in the north.

We are not trying to gloss over the severity of the problems, but the expansion of programs and services are beginning to counterbalance addiction problems.

Mr McConnell may appreciate knowing the Chippewa he referred to are actually another Indian tribe located in the United States; the correct name is Chipewyan. They are one of the tribes of the *Dene* nation, which encompasses many northern Native people: *Dene* means 'People of the Land.'

The Chipewyan are wanderers and, as Mr McConnell stated, village life may prove difficult. When you change the physical community, the social structure changes, and the rules and sanctions for social interaction change. Adding alcohol to this environment has had serious social consequences.

Our northern staff is concerned that the problems in the north were emphasized while our growing resources to combat them were not also identified.

I hope this gives **The Journal** readers a further understanding of SADAC's role in north Saskatchewan.

Thank you again for Mr McConnell's special efforts to cover our Saskatchewan story.

Danni Boyd
Associate executive director
Saskatchewan Alcohol and Drug Abuse Commission
Regina, Saskatchewan

The Journal

A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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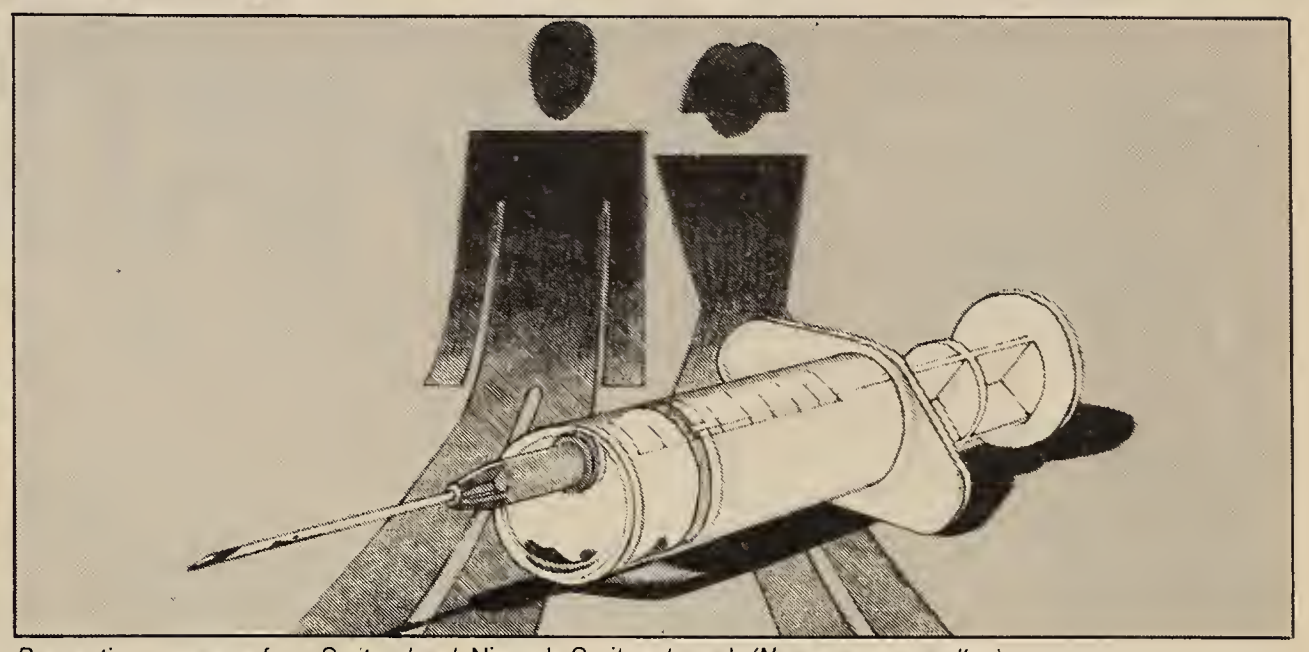
The Journal

Swiss in 'all-fronts war' on HIV

Staub: a dazzling compendium against spread of the virus



Prevention message from Switzerland: Niemals Spritzentausch *(Never swap needles)*

Zurich

Most foreigners associate Switzerland with the obvious: banks stuffed with money and gold, marvelous scenery, trains that run with the precision of the clocks, chocolate, cheese. Few associate it with the highest number of AIDS cases in Western Europe and a serious intravenous (IV) drug use problem.

Switzerland is steeped in religious history — John Calvin and the Pope's Swiss Guard — but that is no hindrance at all to very sharp, very public, and very forthright campaigns to contain spread of the HIV virus.

On the evening television news earlier this year, for example, the country's top news anchor, the avuncular Charles Clerc, pulled out a foil packet, unrolled a condom down his fingers, and said: "Ladies and gentlemen, this little thing could save your life."

Not a single letter of protest was received by Swiss television.

Aline Janett, MD, of the Swiss Federal Office of Public Health in Berne, and Roger Staub of the Swiss AIDS Foundation in Zurich, talk with Mr McConnell.

ZURICH — There are 226 cases of AIDS in Switzerland in a population of 6.6 million. Anonymous blood tests show that among those HIV-positive, 73% are men and 27% women. By 1991, it is estimated there will be 3,500 people with AIDS and 25,000 will be HIV-positive.

Aline Janett says the majority of AIDS cases are still among homosexual men, followed by IV drug users.

It is also obviously in the heterosexual population; at least a dozen cases involving men and women report heterosexual transmission as the sole risk factor.

It is impossible to know how many of the HIV-positive women are sexual companions of IV drug users. But, Dr Janett considers "it is a good supposition that many are."

There is now a major effort to make methadone maintenance more available and in favor of providing free needles and syringes.

Dr Janett says the individual cantons in Switzerland may differ in how they want to distribute free needles and "we say give them out as you like, but give them. If some cantons only want the exchange (done) by a doctor or a pharmacist, we say that is only secondary."

Dr Janett and her colleagues work closely with the Swiss AIDS Foundation — which is financed, for now, mainly by the government but seeks private funds — and are in constant contact with Roger Staub, who is on secondment to the foundation from the federal office.

The foundation may operate from modest offices in a quiet Zurich street, but in 18 months, it has developed a dazzling compendium: slick television and movie commercials; imaginative condom packaging; factual pamphlets, posters, booklets, and information aimed at specific audiences from readers of womens' magazines, to IV drug users; and, a Heavy Metal "Stop AIDS" pop-chart hit.

And Mr Staub, a dynamo of ideas and activity, and his colleagues are not afraid to hit the streets and enter the murky world of junkies and prostitutes: passing out sterile needles and condoms to IV drug users; and advising and cajoling as best as possible the prostitutes who flit in and out of the shadows of the main railroad stations.

One of Mr Staub's most frustrating moments was early in the campaign and his first contacts with drug abuse experts who told him in effect, "It is our field, you don't work in it, and it is our problem." Naturally, he ignored them.

Timing their visits with military precision, Mr Staub and volunteers went into the streets and parks in Zurich, the city with the largest problem, where addicts congregate.

"If you are there before, say, 10 am, while the junkies are waiting for the dealers, you have plenty of time to talk to them. But you have to time it, because the moment the dealers arrive, they are away to buy their drugs and to shoot up.

"We found that the IV drug users

(See Next, p8)

AIDS in Europe

McConnell

Reporting this month from Switzerland and Denmark, The Journal's Contributing Editor Harvey McConnell continues his series on AIDS in Europe (The Journal, October). Many countries there are moving ahead with frank and vigorous prevention programs promoting an end to needle sharing among intravenous drug users, use of condoms, and more methadone maintenance programs to contain the spread of the human immunodeficiency virus (HIV).

Liberated Danes: efforts extend to women

Copenhagen

Denmark has for years had a liberal attitude to sexual matters and non-opiate drug use. Neighboring countries have seen Copenhagen, especially, as the conduit in the past for drugs into Scandinavia.

Today, Denmark has been galvanized by the threat of AIDS, and some of the old ideas are falling away, as Mr McConnell found in conversations with Lone De Neegaard, MD, national AIDS coordinator for the Danish Board of Health, and Daniel Folke Larsen, MD, medical officer of health for the county of Storstrom, a large area south of Copenhagen.

COPENHAGEN — At one stroke, a late-summer announcement in the Danish parliament by Social Affairs Minister Mini Stilling Jacobsen that intravenous (IV) drug users here must be offered the opportunity of methadone maintenance removed a major stumbling block for action against sprcad of the HIV virus.

It ended a debate that has divided the chemical dependency field for years; whatever the negatives of mcthadone maintenance, the threat of AIDS overrides them.

It was a rclief to Lone De Neegaard. "Until that announcement, it had been very difficult to get the Ministry of Social Affairs to say it, and it has been difficult for a lot of people in the system to use it.

"There was the old policy with the philosophy that you don't give alcohol to a drunk, and methadone would seem the same. We say, 'that might be right, but now we have a different situation and we have to do it because AIDS is such a great threat.'

"We worked constantly within different ministries and the national commission and kept saying if the minister would clearly send out the signal that we do need to think in these terms, this would give the ones who would use it the reason to do so.

"Methadone must be offered, we must be able to have it for long-term use. It is not the only thing to do, of course, but we must have it."

Dr De Neegaard, who was new to the field of intravenous (IV) drug use when she became coordinator, has found that the decision to make methadone freely available has upset many doctors and police officials, who say it means street sales of methadone. "And, while this is not untrue, it is secondary.

"It is as important to prevent the next one from becoming HIV-positive as it is to maintain the addicts who are already positive."

The debate over supplying IV drug users with clean needles has not been as fierce. For some time, users have been able to get free needles from pharmacists in Copenhagen, and slot machines with two needles and two syringes are placed around the city where drug users congregate.

The methadone debate helped Danish society focus on a problem to which they had paid little attention — IV drug users. And it extends to women who are users and resort to prostitution to help sustain their drug habit.

"One of the first things we did was to make the general public aware of the problems of prostitution," says Dr De Neegaard.

The point was made with an advertisement which ran on tele-

(See Methadone, p8)

De Neegaard: street sales

Multi-language brochure: targeting young tourists

Next? A 'safe shooting-up pack' for addicts

(from page 7)
are conscious about needle sharing, and they would read our leaflets. We gave out free needles and condoms."

Lo and behold, "this changed the mentality of the drug abuse experts. They were completely against giving out free needles when we started, but now there are street workers who go out to distribute them, and there is cooperation with pharmacists to supply them as well."

The barriers have dropped in many minds against methadone maintenance as well.

Mr Staub works with a team of brilliant designers on the entire range of prevention materials and not just on print material. One of their most imaginative leaps, now coming to fruition, is a two-condom pack which looks the same as a pack of 20 cigarettes.

Swiss restaurateurs and bar owners have been sold on the idea of putting the pale blue and beige packs into vending machines: by the end of the year, condom packs will be side-by-side with cigarettes in some 4,000 outlets around the country.

"This means men and women can buy them discreetly without anyone else knowing."

. . . never with used ones

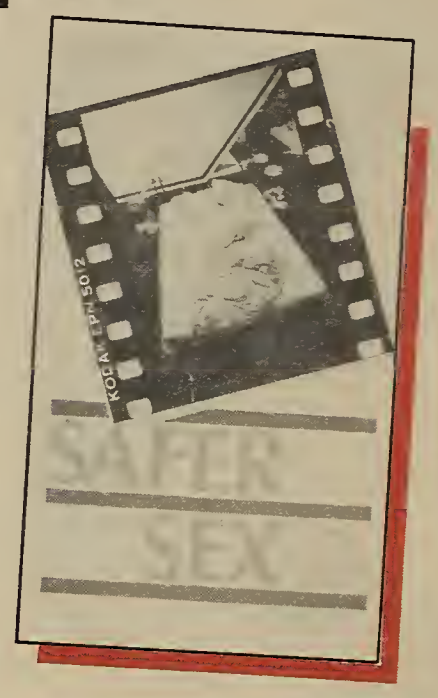
One good idea leads to another, and the team is now working on a similar idea for IV drug users. "We would like to develop a kind of 'safe shooting-up' pack containing a sterile needle, cotton, condom, information leaflet, and even a way to dispose of a dirty needle. We will be selective and put these packs only in machines in areas where junkies congregate. We have to do everything we can to stop HIV spread."

Earlier this year, in a direct campaign to Swiss homosexuals, thousands of packs containing two condoms, a lubricant, and a symbolic "safe sex" safety pin were passed out one weekend in bars and saunas. This has lead the foundation to supply mail-order condoms made by a reputable manufacturer specifically for gay male sex.

Mr Staub finds that most prostitutes who are also drug users are aware of the problem of HIV infection. But, they still subject prevention workers to a recurrent theme: "They tell us they do want to use condoms, but the problem is many men do not want to use them.

"If a prostitute asks a man to use a condom and he refuses, then I agree with the prostitute: it is the man's problem. A man can protect himself if he wants to do so."

Like his counterparts in the Netherlands (**The Journal**, October) and Denmark (see below), efforts by Mr Staub and his organization exist in the sea of commercial sex. "We have designed a poster which shows a condom as if it were a



painting. We are trying to get it put up in every sex shop, and it will also run in the sex magazines."

The team has also persuaded makers of pornographic videos to insert a graphic "safe sex" message in the lead-in portion.

Readers of sex-contact magazines may have been shocked recently when they received a questionnaire from the foundation. However, of the 5,000 sent out 600 readers replied, and a follow-up is planned.

Mr Staub is repeatedly struck by the enormous amount of cooperation he has received: television stations have been pleased to run the foundation's artistic but direct advertisements, which are aimed at heterosexual couples and IV drug users. The stations' only request has been for new ones which are now being produced.

One of the most effective ads for IV drug users, or those who might be tempted to try, is of a shadowy figure spray-painting a syringe and needle on a wall and then in German, French, Italian, or English, the slogan "One hit is all it takes."

The billboard industry sees to it that foundation posters are placed in prime sites, such as entrances to railroad and subway stations. Newspapers carry large display ads featuring questions about AIDS for parents and children; commercials are produced especially for teenagers who go to the movies, and more than 6,000 packs with written material and slides on sex education and AIDS have been sold to doctors and teachers.

All of this has been done with modest funding.

Mr Staub has two problems: "The first is that I am only 30, and this is a very conservative country; I do not have the contacts with business and industry. And, the idea of volunteerism is just not European: a walkathon to raise funds would be impossible — noboby would come or donate money."

None of this, of course, will dissuade Mr Staub from approaching industry, especially the super-rich, Swiss pharmaceutical companies which have yet to make any large donations.

Mr Staub smiles, but does not hedge, when asked, obviously for the umpteenth time, why a rich country like Switzerland has the highest number of AIDS cases of any Western European country. Because it is rich.

"I think it was introduced quite early into this country by many, many people travelling abroad, especially gay men, many of whom have good jobs and earn the salaries of family men. The early cases are probably among older gay men who went to San Francisco in the late 1970s and to Africa."

That is history.

Today, the focus is on containing as far as possible the spread of the HIV virus.

Methadone may help drug-using prostitutes

(from page 7)
vision and in newspapers; it produced enormous repercussions but not in the way one might expect. A night-time shot of a street in Copenhagen's red-light district carried the caption: "You can get more than a quick fuck." And it bluntly warned people to be aware of the risks of AIDS and to take precautions with condoms.

"We didn't expect an immediate effect, but we heard immediately from girls in 'massage parlors' who said the ad had ruined their business. Taxi drivers reported that traffic in those streets had dropped dramatically."

This ad was followed soon after by broadcast of a television documentary produced by a leading Copenhagen tabloid newspaper. The program followed an AIDS patient through his last three days of life and included an interview with a prostitute.

The prostitute was direct: "I get twice as much without a condom." Her feeling was: "I know I'm not going to be here much longer, it may be drugs, or it may be AIDS. But, I don't understand the men, as I know they go home to their wives."

Dr De Neegaard: "One of the things we are saying is that you have a responsibility for your own life. We have a slogan: 'It takes two to get AIDS.' You decide, yourself, if you want to be the one."

She is under no illusions that reaching IV drug users is an easy task. "We have to think in different terms."

While the current focus is on the IV use of heroin, Dr Folke Larsen is worried there may be a new wave of IV amphetamine use in the country.

"Our population of drug addicts has not changed much in the past five years or so, and most of them are older. Only a few younger ones are being seen at the moment.

"But, because of amphetamine use and solvent sniffing among some young people, we are expecting some of them to turn to IV amphetamine use. These young people are not starting with the needle; but, we fear many old-time amphetamine abusers will try to get them to use the needle."

Dr Folke Larsen said the emphasis in Denmark must now shift from treatment of addicts by individual doctors to clinical care for addicts. Methadone-maintenance programs can provide the impetus, he said.

"The main goal now, from the public health point of view, is to see that we are not spreading disease, and one way to keep drug addicts out of the area of prostitution is to give them enough methadone so that they won't need extra money for drugs," Dr Folke Larsen added

There is a possibility that both male and female drug-using prostitutes may find methadone can stabilize their lives. They may even become more healthy and better dressed and revert to a higher-class form of prostitution.

Dr Folke Larsen is sanguine: "We don't think we can get them to protect their clients, so we have to do it in other ways and keep them off the streets."

Prostitution is illegal in Denmark, but penalties are so mild it is *de facto* legal. The code-word is "massage," and newspapers carry many ads for such services.

To find out how many prostitutes might be HIV-positive, the government offered free testing; none of those who responded was positive

The flip side? Many of the women wanted a statement they were not infected. "Of course that was refused; there is not going to be any government seal of approval."

Dr Folke Larsen says "many drug addicts don't care about their own lives and even less about ours. So we have to compromise and work with police and others and use street workers with the aim of saving lives."

He actively promotes condom use whenever possible, attending pop and jazz festivals where he and his colleagues set up "counselling" tents, distribute free condoms, and talk to anyone about any aspect of AIDS, HIV infection, and condom use.

"We have cartoons for kids. We go on local radio stations with questions and answers. We show people how to use condoms properly. We advise teenage boys and girls to carry condoms with them at all times. Our message is that this is the only way we can protect each other from AIDS."

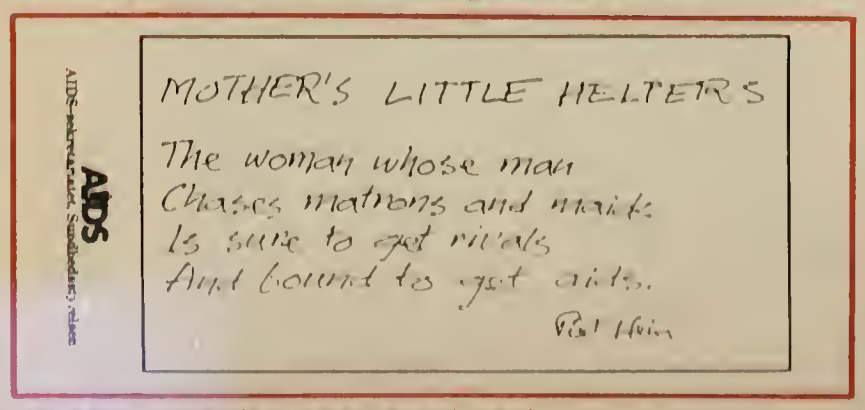
One encouraging feature of the drug-scene Dr Folke Larsen has observed in recent years is the decrease in use of drugs (except alcohol — beer remains part of daily life here) by young Danes. Even marijuana is simply not cool.

"I definitely feel that for a lot of young people the idea you can't go through this world without trying (drugs) is in fact changing; it is not *in* to think about using drugs."


Folke Larsen cartoons for kids

The Journal
Addiction Research Foundation
33 Russell St, Toronto M5S 2S1

Red-light district ad: blunt



Matchbook covers: innovative prevention tool

VOL. 1 NO. 4 NOVEMBER 1987

INSIGHT

by Joan Marshman, PhD

'We have an unprecedented opportunity at this moment to make real progress.'

ADDICTION RESEARCH FOUNDATION'S ONTARIO REPORT

New videos from ARF

page 4

New funding for youth treatment

TORONTO — The Ontario government announced in September that it will spend an additional $5 million dollars annually to reduce drug and alcohol addiction among young people.

A further $750,000 a year is earmarked to hire and train full-time health promotion and prevention workers for the same target group.

The government is allocating the $5 million to the development and expansion of community-based services. Community groups were asked to submit program proposals through their district health councils.

Joan Marshman, PhD, president of the Addiction Research Foundation (ARF), welcomed this news: "We've recognized, in our foundation's goals and objectives, that we must give attention to the unique needs of this age group. The announcement is entirely consistent with our own analysis of current needs.

"We look forward," Dr Marshman added, "to sharing our experience, particularly in the treatment of young people, with community groups and district health councils as they develop new proposals for the target group."

The planned expenditure on youth workers also holds promise, says Dr Marshman.

"We've long recognized at ARF that treatment services alone are not a sufficient answer to drug-use problems. So, it's exciting to see a program which will link workers engaged in outreach prevention activities to existing, local addiction programs.

"We see this as a major step forward in the development and support of prevention programs in Ontario," Dr Marshman said.

Information line gains in popularity

TORONTO — Telephones are ringing more often at the Addiction Research Foundation's Drug and Alcohol Information Line.

Calls increased by 36% this summer, compared with the same period last year. Ron Hall, head of Information and Promotion, Addiction Research Foundation (ARF), credits ARF's new promotional campaign for the increase.

Always a popular service with Ontario students and parents, the information line is steadily expanding:

- Liquor stores in Ontario featured *It's For You* counter-top displays this summer to advertise the telephone line.
- Schools and libraries across Ontario are now receiving promotional materials on it.
- Subways and buses already feature the *It's for You* message.
- The information line is taking an active role in the federal-provincical *Really Me* campaign on alcohol and drug use, aimed at young people and their families (see page 2).

Ontario awareness week events set to go

TRY HUGS NOT DRUGS

TORONTO — Drug/Addiction Awareness Week arrives this month, and it's bigger than ever before. Community groups and professional associations are strongly supporting the event and Addiction Research Foundation (ARF) staffers have been leaders in planning and organizing a wide range of activities around the province.

This year the event, taking place from November 15-21, is tied into the federal government's National Drug Strategy.

ARF's slogan, **Try Hugs, Not Drugs,** will be a familiar sight throughout the week.

Other highlights will include:

- ARF's Community Achievement Awards, recognizing local and province-wide achievement in the field of alcohol and other drug addiction;
- two drunk-driving mock trials in Peel region high schools, with local lawyers and judges participating;
- no-smoking, no-drinking challenges on university and college campuses around Ontario;
- newsletter updates for physicians and lawyers; and,
- electronic subway signs flashing messages about the week's activities.

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Elinor Caplan

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Drug Awareness A NATIONAL FORUM

Next issue —

January, 1988

Have a good holiday!

INSIGHT

Awareness is not enough

Social climate sets the stage for change. Working in the addiction field, we know the truth of this statement first-hand. Public opinion and society's attitudes can help shape, or erode, our efforts.

Today's social climate is certainly encouraging for those of us committed to reducing the abuse of alcohol and other drugs in Ontario. There are definite signs that our message is getting through. ARF's research indicates that Ontarians are very concerned about these problems. They are taking these issues more seriously than perhaps ever before. Confronted with the consequences of addiction among their friends and families, they personally recognize the need for solutions.

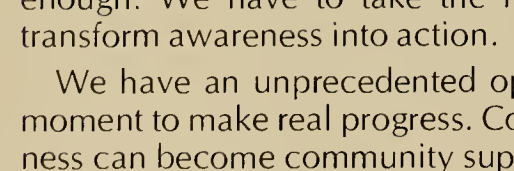
From our perspective, this awareness about addiction problems is good news. But on its own it will not be a remedy. Awareness alone is not enough. We have to take the next step — and transform awareness into action.

We have an unprecedented opportunity at this moment to make real progress. Community awareness can become community support for our work — and community action in response to our concerns. If we can follow up with the information, advice, and programs that answer the province's needs, we will be the catalysts for significant change in Ontario.

A challenge such as this demands leadership. It demands a firms sense of direction. And it demands a close-knit collaborative network, so that the community initiatives are in the right place, at the right time.

Drug/Addiction Awareness Week 1987 arrives in this atmosphere of dynamic potential. The public awareness and information efforts of the National Drug Strategy are reinforcing provincial initiatives. A media campaign, the National Forum, an information booklet and increased business/government collaboration all point to a higher profile for Awareness Week 1987 — and for the issues.

Now it's time to use our resources — new and old — to build on our previous gains in growing public awareness.



Joan A. Marshman
President, ARF

ADDICTION RESEARCH FOUNDATION'S
ONTARIO
REPORT

Published by the Addiction Research Foundation

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Campaign focuses on youth and their parents

TORONTO — Canadian young people are the targets of a multi-million-dollar media campaign promoting the benefits of a drug-free lifestyle.

The *Really Me* campaign, part of the National Drug Strategy, is broadcasting its message in television and radio advertisements, billboards, videos, and a host of resource materials. Dialogue between parents and children is a key theme in the program.

The TV and radio ads started airing across Canada in June, and other segments of the campaign are on their way. Four million parents received a coupon for a brochure about drug use in their family allowance cheques last month, and National Drug Awareness Week will extend the campaign's reach further.

Provincial and territorial addiction agencies are collaborating with the federal government on this project, and the Addiction Research Foundation (ARF) is an active player.

ARF took part in creating the television ads and is identified in them as a provincial resource. The summer TV ads feature young people thinking and talking about factors that influence drug-related decisions. New English-French TV ads will centre on the parents of pre-teens.

ARF's Drug and Alcohol Information Line (see page 1) will also boost the campaign, by providing information on drugs to Ontario young people and their families. The government guide on drug use will be available through the ARF telephone line later this month. Federal resource materials such as this will be distributed through ARF, along with the foundation's own publications.

The campaign's aim is to encourage communication between parents and children. In drawing attention to drug issues and increasing public awareness, *Really Me* hopes to make a powerful impact on both young people and their families.

A significant portion of that impact will flow from community resources. By plugging into the network of addiction organizations across Ontario, parents and kids will gain access to reliable drug information and counselling services.

Self-esteem is widely recognized as the key to reducing drug use among young people, says Henry Schankula, ARF director of Inter-Organizational Affairs. As a member of *Action on Drug Abuse*, an arm of the National Drug Strategy, Mr Schankula is closely involved with the *Really Me* campaign.

"We have to build self-esteem and reinforce positive decision-making," says Mr Schankula. "Young people using drugs need to understand the consequences of this decision-making, on employment, on economic decisions, and on social interaction.

"With youth, if you provide genuine, factual information, in use, in terms of effects, alternatives, you can di more positive goals."

Mr Schankula is enth ARF's role in the public "We want to be as respo ble to the information needs of the people in t through the telephone public forums, and thr tions like **The Journal** an ***port***."

Caplan appointed health minister

TORONTO — Elinor Caplan has been appointed Minister of Health in the new Ontario provincial government.

Ms Caplan is the first woman to be formally appointed to this portfolio. She took her place in the Legislature on November 3. The former health minister was Murray Elston.

Dr John B. Macdonald, chairman of the Addiction Research Foundation (ARF), praises Ms Caplan's appointment:

"Elinor Caplan comes to the Ministry of Health with a reputation as one of the ablest ministers of the new government. She brings with her a personal commitment and a mandate from the premier to encourage innovation in the Ontario health system. "This commitment," adds Dr Macdonald, "is consistent with the foundation's emphasis on the development of coordinated community services and its priority for health promotion. We wish her well in her new challenge."

Cross-country networ at the national forum

WINNIPEG — Addiction Research Foundation (ARF) staff took part in a Winnipeg conference on the National Drug Strategy last month.

The National Forum, held in Winnipeg October 7 and 8, attracted more than 150 delegates from across Canada. They came to discuss planning and implementing drug awareness programs under the federal government's National Drug Strategy.

The conference's theme was Heading for the Future, with the emphasis on practical courses of action.

Highlights of the conference included:

- an opening address by H. David Archibald, president of the International Council on Alcohol and Addictions and founder of the ARF;
- a luncheon speech by Health and Welfare Minister Jake Epp, proclaiming National Drug Awareness Week, the third week in November; and
- an address by Joan Marshman, PhD, ARF president, discussing the National Drug Strategy and Action on Drug Abuse from her perspective as chairperson of the Federal/Provincial Advisory Committee on Alco Drug Problems.

The Forum provide with an unusual opportu with addiction worke Canada. During the tw ence, workshops sparke exchange of ideas and in

Dr Joan Marshman: strong sense of the pow nity-based action. The knew the importance public awareness in ord public support."

Henry Schankula, cha Forum, noticed "an exci ing of cooperation, coo togetherness that is rarel meetings. We had people es communicating with the trenches."

"What was most em conference participant K ARF community consul ton, "was the chance to across the country. Altho in diverse groups, we problems in common — of goals."

Drug Awarene
A NATIONAL FOR

ARF's school drug-policy

TORONTO — A new policy from the Addiction Research Foundation (ARF) promises to be an important tool for Ontario educators who are confronting student alcohol and other drug use.

Under development for the last two years, the model policy was created by the ARF for school boards throughout the province. Entitled *Alcohol and Drug Use by Students: Policy Development for School Boards,* the document provides educators with straightforward strategies on coping with drug problems in schools.

The policy is the first of its kind in Ontario. Until now, schools have had to rely on their own resources to handle the issue of drug use. No generic guidelines have been available.

"This policy will ease the load on boards of education," says Kathy Barry, chairperson of the working group that devised it. Ms Barry is ARF's health promotion coordinator for the Eastern Region.

LaRocque: basis for action

Barry: springboard

Other committee members are Gloria Silverman, community consultant, West/Central Metro Centre; Andrea Stevens-Lavigne, health promotion program consultant, Metro Toronto Region; Rob Simpson, executive director, Wellington-Dufferin District Health Council; and Robert Solomon, law professor, University of Western Ontario. The committee worked under the direction of John LaRocque, divisional director, ARF's Community Services division.

"We wanted to save the boards some time," says Ms Barry, "and provide them with expertise that they frequently don't have. Instead of taking a year to develop a comprehensive policy, they can use ours as a starting point and cut down their time by six or eight months."

The top three drugs in Ontario schools — alcohol, tobacco and cannabis — are the primary focus for the new ARF policy, although all drugs are included. Alcohol continues easily to outdistance the other two drugs in its popularity among students (***Ontario Report,*** September).

The model policy is accompanied by a detailed guide, to give educators an overview of drug issues and illustrate how they can address them. Their legal rights, powers, and obligations are also outlined. Schools will be able to customize the model policy to suit their own needs.

To combat drug use, the policy recommends a three-pronged program:

- prevention
- intervention
- disciplinary action

The prevention segment of the policy emphasises the importance of drug education. According to the ARF guide, the best preventative measure is a comprehensive curriculum that starts in kindergarten and continues through Grade 13. The ideal curriculum would integrate drug education into other subject areas.

"Prevention is a key component of the overall program," says Mr LaRocque. "Kids don't start school with drug problems. They develop them while they are students. So, schools can be a big influence in terms of preventing the problems in the first place."

Intervention is the second stage of the policy. Despite a school's best efforts, some alcohol and drug problems are bound to occur. The ARF guide urges early intervention — a system that will identify problems and establish appropriate responses. Educators are provided with clear direction on the steps they can take to address various levels of drug use.

Confidential counselling on drug- and alcohol-related concerns is a vital part of such intervention. Students, themselves, may ask for this help, or parents or employers may request help on a student's behalf.

A school's intervention program will depend on its particular resources and the needs of the individual student. Where problems are mild, only brief intervention tactics will be necessary. If an initial assessment indicates there is a serious drug use problem, the school may be able to provide its own counsellor for the student. When these resources are not available, the school can turn to appropriate community services that offer addiction programs, such as a mental health centre or a youth clinic.

The third prong of the strategy centres on disciplinary action schools can take to discourage drug use. A drunk student, for example, may be reprimanded, if it is a first offence, and the student's parents will be told about the incident. Penalties are stiffer for a second episode.

The ARF policy is a prototype for Ontario schools, representing the ideal game plan for a drug-free school environment. But, it is expected that a number of school boards may choose to use the policy as a springboard to develop or refine their own policies.

"We'd like the boards to take our model, strike a policy development working group, and tailor the ARF policy to meet their demands," says Ms Barry. "They can ask themselves, 'What is missing in the policy we have now? What new information does the ARF policy have that we can use in our own?"

"We want it to be the basis for action," says Mr LaRocque. "It sets out the values and principles that a board can adopt. Most boards already have some kind of programming. They should see this policy as a way to improve what they are now doing."

In February, a conference jointly sponsored by the ARF and the Ontario Council for Leadership in Education Administration (OCLEA) will introduce the document to an audience of approximately 100 school trustees and administrators. The conference, to be held at ARF's Toronto headquarters, will focus on student alcohol and drug use, reviewing ARF's policy and its relevance to school boards in detail.

Prevention: kids don't start school with drug problems

After the conference, the policy will be distributed to boards of education throughout the province.

The ARF initiative comes at a time when a number of school boards are showing a growing awareness of alcohol and other drug use and its implications for student welfare.

"Progressive boards are catching on to the fact that health and education are inter-related," says Mr LaRocque. "The first responsibility of school boards is the student's education. The student's well-being comes next.

"Where educational and health concerns intersect, the effects are powerful," says Mr LaRocque. "And, we tell the boards, drugs have the biggest impact on student health."

The policy's architects have high hopes for its future.

"We'd like to see a modified version in every school, tempered by the school's own philosophy and its resources," said Ms Barry.

"I'd like to see a representative from every school board at the OCLEA conference," adds Mr Larocque.

"If there is any significant gain to be realized in curbing alcohol and drug use, school boards have to get involved. They could be the most important force in this effort."

Facts on the law for educators

TORONTO — Educators don't realize how much power they have to stop school drug use, says an ARF consultant.

"Schools have more than ample authority to act on alcohol and drug use," says Robert Solomon, a law professor at the University of Western Ontario. "To some extent, there is a lot of misinformation — even a morbid fear — about the law in this area."

Professor Solomon is a member of the ARF committee that formulated a model school policy to curb alcohol and drug problems among students. He co-authored two appendices to the guide which explain the legal rights, powers, and obligations of educators and summarize Canadian alcohol and drug laws.

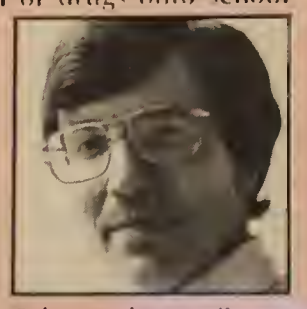
School boards face thorny decisions on the issue of student drug use. Does a school have the right, for example, to search a student's locker for drugs or alcohol? What kind of action can a principal take when a student arrives on school grounds drunk?

The new ARF document clarifies the legal position of educators when such cases arise. School boards will discover that the law is often squarely on their side.

Mr Solomon: "According to the Trespass Act under Canada's Criminal Code, the school board owns the school property. Therefore, the board has the authority to say students cannot bring alcohol or drugs onto school grounds."

Other legal points raised in the ARF guide may surprise some educators. It is a federal criminal offence, for example, for a person less than 16 years old to smoke in public.

"The bottom line," says Mr Solomon, "is that the law is not an obstacle for school boards which want to implement alcohol or drug policies. It provides them with more ammunition than they will ever need."



Solomon: bottom line

Building bridges to reduce drug use

TORONTO — Partnerships between community organizations and the Addiction Research Foundation (ARF) are expected to strengthen with the announcement of a new staff appointment at ARF.

In September, Joan Marshman, PhD, president of ARF, appointed Henry Schankula to the newly created post of director of Inter-Organizational Affairs. The position underscores the foundation's commitment to closer community ties.

Mr Schankula, a 25-year veteran of ARF, will be responsible for developing and enhancing ARF's links with provincial, territorial and governmental organizations. In particular, he is spearheading ARF's contributions to the National Drug Strategy (***Ontario Report,*** September).

Mr Schankula is clear-eyed about his goals in this new position at ARF. "We want to build excellent relationships with other organizations," he says. "It was evident to us that we needed to work on improving our partnerships. We are recognizing now that we work synergistically, and that we have the same objective — to reduce the hazardous consequences of alcohol and drug use in Ontario."

'We have to change the climate in our society so that alcohol and drug use are not seen as a way of escape.'

Schankula

ARF's bridge-building holds enormous potential, says Mr Schankula. "It produces a cost-effective network that can significantly reduce or eliminate alcohol and drug abuse in Ontario. Private-sector organizations, for example, are a lever for change. They can influence environmental and social areas and act as advocates. They have access to political bodies.

Some of the community organizations Mr Schankula is involved with on ARF's behalf are the Drug Education Coordinating Council (DECC), the Ontario chapter of People to Reduce Impaired Driving Everywhere (PRIDE), and the Parent-Teacher Association. For example, ARF helped present a Toronto conference on drug abuse last month with the DECC.

A recent project with the Ontario Association of Chiefs of Police offers another illustration of Mr Schankula's outreach efforts. Later this fall, the association will launch a new educational program police officers can take into classrooms across the province. Accompanied by a video and back-up resources, the program teaches the consequences of alcohol and other drug use to Grade 7 and 8 students. The project is a joint collaborative effort for the association and ARF.

The National Drug Strategy (NDS), a five-year federal plan to help curb drug abuse in Canada, is the focus of much of Mr Schankula's liaison activities. In his role in *Action on Drug Abuse*, a component of the NDS, he is chairperson of the national working group on community action funding programs. The committee is assisting Ontario groups seeking government funding for program development.

Mr Schankula also chaired the National Forum in Winnipeg (see page 2), a conference organized to explore the National Drug Strategy in depth.

His 25 years of experience at ARF are likely to serve Mr Schankula well in his newest role. Formerly director of Education Resources, he had also held the post of director of administration as well as other administrative positions.

"He has a good working knowledge, not only of the foundation, but also of the field throughout Ontario, Canada, and also internationally," says Dr Marshman.

"For some time now, he has been a very energetic and effective contributor to other addiction-related organizations in the province, particularly in those emphasizing prevention programming."

Mr Schankula welcomes the opportunity to extend his expertise. "I'm comfortable with the issues. I know what questions to ask. I'll be able to help organizations by utilizing what I've seen, what I know, and what I can do."

He believes the current collaborative emphasis at ARF is in line with society's new approach to alcohol and drug use. "It's an age of partnerships," he observes. "We have to work together in order to be cost-effective."

Intensive work lies ahead for these networks, Mr Schankula believes. "We have to change the climate in our society so that alcohol and drug use are not seen as ways of escape. It will be a long-range effort and our effectiveness will be measured by how much these problems are reduced."

NEW from ARF

The Choice Is Yours

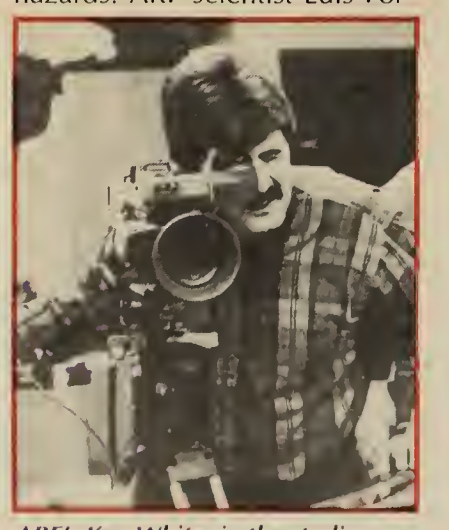
This 29-minute video is for use with students in Grades 8, 9, and 10, and includes segments on cocaine and crack, cannabis, solvent abuse, and alcohol. Produced by the ARF in cooperation with the Ontario Association of Chiefs of Police, *The Choice is Yours* will be used by the police in classrooms across Ontario. Following this initial use, the video will be made available to Ontario purchasers. Currently, it is available in both French and English to purchasers outside Ontario.

For more information: Marketing Services, Dept OR, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1, or call collect (416) 595-6059. $150 outside Ontario.

Inhalant Abuse

Developed for teachers, parents, and health professionals, this 26-minute video documentary describes the issues of solvent and inhalant abuse (sniffing glue, gasoline, etc) and provides recent information on the health hazards. ARF scientist Luis Fornazzari outlines permament brain damage caused by inhalant abuse. Produced by the ARF and the National Native Alcohol and Drug Abuse Program.

Order from Marketing Services, Dept OR, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1. Call collect (416) 595-6059. $75 in Canada, $150 elsewhere.



ARF's Ken White: in the studio

Cannabis and You

Facts and misconceptions about cannabis are dealt with in this 12-minute video aimed at students in Grades 8, 9, and 10. Students interviewed express concerns about peer pressure to try cannabis. The video encourages positive attitudes to help young people avoid cannabis use. Available in French and English.

Order from Marketing Services, Dept OR, Addiction Research Foundation, 33 Russell St, Toronto, M5S 2S1. Call collect (416) 595-6059. $95.

What When Where

Assessment Training — Beginning November, the Kitchener ARF Centre is offering a program of on-site, practice training for new assessment workers. The program will help new workers develop assessment, treatment planning, and case management skills. Contact: Darryl Uptald (519) 579-1310.

Teacher Training — Through December. The ARF Halton Centre has begun Phase Two of training for 200 teachers and staff of the Halton Separate School system. Halton Centre staff will familiarize teachers with an ARF-designed curriculum on alcohol and other drug use aimed at Grades 3 to 10. Contact: Steven Moore (416) 632-2436.

Workshop for Seniors — November 16, Peterborough Public Library. The issue of prescription drug use among seniors will be examined in a half-day workshop co-sponsored by the ARF Peterborough Centre and the Peterborough Senior Citizen's Council. Guest speakers will include Wafik Raouf of the ARF Northeast Metro Centre (Toronto). Admission free. Contact: Brian Mitchell (705) 748-9830.

Treatment Panel — November 18, 1 pm, Union Gas building, Hamilton. A panel presentation by eight different treatment agencies is being coordinated by the ARF Hamilton Centre. The event, requested by the Employee Assistance Council of Hamilton Wentworth, includes presentations by ARF's Program for the Employed Drinker and a panel discussion. $5 admission for non-council members. Contact: Rick Csiernik (416) 525-1250.

Intrusion or Benefit? — November 19, Canterbury Inn, Sarnia. The ARF Chatham/Sarnia Centre and School for Addiction Studies present a one-day workshop on workplace drug screening. Speakers include Bruce Cunningham, chairman of the ARF task group on drug screening, and Bhushan Kapur, director of ARF's clinical laboratories, outlining methods of analysis and accuracy. Contact: Angelina Chiu (519) 337-9611.

EAP Meeting — November 25, Belleville. The ARF Belleville and Peterborough Centres in cooperation with the Quinte Advisory Council will hold their bimonthly meeting on Employee Assistance Programs (EAPs). The meeting is open to anyone involved in or interested in learning more about about EAPs, and will include guest speakers and films. Contact: Randy Walsh (613) 965-3774.

Drug screening: misplaced crusade?

Workplace drug testing: corporate responsibility or invasion of privacy?

By Karin Maltby

SEATTLE — Random urine screening to detect employees using drugs is a misplaced "crusade" that does not prove impairment and invades the privacy of responsible citizens.

Elaine Kaplan, a Washington, DC, lawyer who is challenging United States President Ronald Reagan's drug-testing program for federal employees, says scepticism is but one necessary defence against mass screening.

But, Peter Bensinger, a former chief of the US Drug Enforcement Administration, maintains the tests are necessary for public safety, as a deterrent against drug abuse, and as a treatment and rehabilitation tool.

Nonetheless, Mr Bensinger, president of Bensinger, DuPont and Associates, who provide drug policy and testing consulting services, acknowledges screening is not a substitute for a corporate drug policy. Furthermore, the tests must be witnessed to avoid adulteration of specimens and be verified by technology such as mass spectrometry and/or gas chromatography (**The Journal**, May).

Ms Kaplan and Mr Bensinger debated drug testing in the workplace at the North American Congress on Employee Assistance Programs (EAPs) here.

Mr Bensinger: "Drug testing is one tool that needs to be added to implementation of education, supervisory training, employee assistance, and treatment. It's a deterrent. Its value is not who you can catch, but to reduce the likelihood of people using drugs on the job.

"I think you can establish compelling reasons to do random testing . . . . It doesn't document impairment (but) will show the presence of an illegal or prohibited substance, or a prescription substance, in somebody's body fluid. If a company takes the position they don't want somebody to work with those potential risks in the person's system, the test is valuable."

Mr Bensinger says that in the interests of other employees, of tested employees, and of the general public, a company has a "significant responsiblity" to intervene against "the potential threats of a drug abuser."

Ms Kaplan emphasized urine tests only indicate the presence of a drug in a person's system. She sees no reason for testing under any circumstances, except for people in positions where public safety is at risk and only then if there is reasonable suspicion of impairment.

"Keep in perspective the number of employees who have no drug problem: people who are not in safety-sensitive positions, who are being asked to reveal personal information, consent to an embarrassing procedure, (inaccurate results), and possibly losing their jobs in the name of a crusade against illegal drugs that ignores the abuse of prescription drugs.

"Think sceptically, and think about whether you really need this at your workplace. Is there that kind of a problem there and is there an alternative?"

In another presentation, David Smith, MD, founder and medical director of the Haight-Ashbury Free Medical Clinics, San Francisco, California, said mass screening is not a panacea for drug abuse.

"If you try to solve your company's drug problem by spending billions of dollars urine screening millions of people, forgetting about education, prevention, and treatment, it's going to make a lot of companies rich.

"But, it's not going to have a significant, major impact on the drug abuse situation."

Dr Smith, also medical director of Merritt Peralta Institute Chemical Dependency Recovery Hospital, said it is clear the answer to addiction is not going to be found in laboratories. Although technology can be of great benefit to understanding addictive disease, in terms of new pharmacologic adjuncts to treatment, for example, it must be put into an appropriate context.

Kaplan: skepticism

Bensinger: potential

Smith: no panacea

AIDS info needed at work

SEATTLE — Fear of AIDS in the workplace can only be addressed after employee assistance program (EAP) counsellors confront their own personal anxieties about the disease.

This process is vital for counsellors. Many people with AIDS are in the workforce, and organizations must take responsibility for handling the impact of the disease on both patients and their co-workers to ensure organizational stability, employee well-being and safety, and compliance with the law.

Alan Emery, PhD, told delegates here at the North American Congress on EAPs: "You can't talk about AIDS (to employees) unless you can talk about sex, drugs, and homosexuality . . . not to change your moral values, but to be clear on what they are and what relationship they have to this issue."

How AIDS is and is not transmitted is the most important message EAPs can convey in the workplace, he said.

"It's legitimate to say you can't get AIDS at work unless you're doing something you're not being paid to do," said Dr Emery, an AIDS consultant to many United States corporations and principal author of *AIDS in the Workplace: An Educational Guide for Managers*.

And, top management must be behind the message that AIDS patients have the right to continue to work if they choose to do so.

EAP staff and senior managers must expect fear of AIDS from coworkers and "address it in advance of it occurring to stop disruption." Employees at all levels need basic but comprehensive information to work through their concerns.

Dr Emery: "You have to provide the specific information about how (AIDS) is contracted and how it's not and about the dangers implicit in certain workplace settings."

Coming up in The Journal

- 1988 calendar
- Seniors, alcohol, and drugs
- Headline index

PIONEERS

Addiction: fighting a joint enemy

Soviet/US drug efforts lauded

WASHINGTON — Mikhail Gorbachev will be the first Soviet recipient of a Pioneer of the Year Award to honor his efforts to create an "alcohol-free" country.

The award, sponsored by the Soviet-United States Joint Conference on Alcoholism and Drug Addiction, will be presented in Moscow on November 7, the Soviet national holiday.

Also named Pioneers of the Year, on July 4, were US recipients Betty Ford and Long Island philanthropist R. Brinkley Smithers.

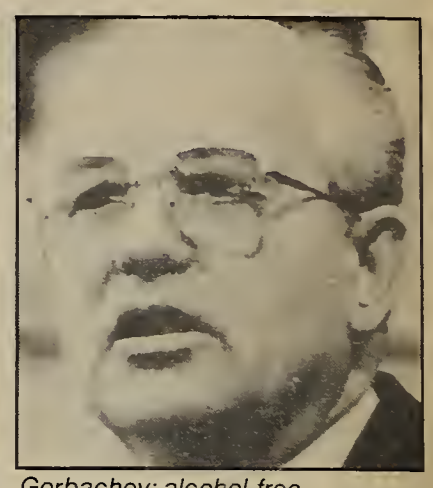
Mrs Ford, wife of former US president Gerald Ford, is president of the Betty Ford alcoholism centre in Rancho Mirage, California.

Mr Smithers is president of the Christopher D. Smithers Foundation and president emeritus of the US National Council on Alcoholism. He has devoted four decades and tens of millions of dollars to fight alcoholism, including donations to the Switzerland-based International Council on Alcohol and Addictions.

J.W. Canty, founder and chairman of the Joint Conference, a non-profit, non-political organization, said the awards and a summer study visit to the US by four Soviet addictions specialists, are aimed at helping the two countries "swap treatment methods to save lives and fight our joint enemy of alcoholism and addiction."

Mr Canty, an Episcopalian minister, founded the conference in Moscow in 1986 with Soviet vice-chairman Nickolay Tchernykh, who heads the All-Union Volunteer Temperance Promotion Society.

Ford: US recipient



Gorbachev: alcohol-free

US begins drug testing federal workers

WASHINGTON — Employees in four agencies under the United States Department of Justice will soon be subject to random urine drug-screening.

Who will be tested will be decided by chiefs of the Federal Bureau of Investigation, Drug Enforcement Administration, Immigration and Naturalization Service, and Bureau of Prisons.

Employees will be tested for amphetamines, cocaine, marijuana, opiates, and phencyclidine (PCP).

Most of those tested will be in positions considered sensitive.

HOWELL

Glib preventionism

Don't get me wrong, I'm all in favor of 'prevention.'

Like everyone else, I want to prevent AIDS and acid rain, overpopulation and ozone layer depletion, alcohol and other drug abuse, starvation and thermonuclear war. But I sometimes get annoyed at "glib preventionism."

There is a glib preventionist at just about every public forum these days. After the subject matter (overcrowded hospitals, youth and drugs, illiteracy, you name it) has been thoroughly hashed-over by the principals on the podium, the glib preventor rises to announce that (a) the answer is simple, and (b) it lies in preventing the problem in the first place. (Cheers, applause).

At this point, the moderator points out that it is questions not statements that are being solicited from the floor; does the glib preventor have a question? Of course he does, you bet he does. Why have the authorities been so stupid as to ignore prevention in the past? (More cheers and applause.)

The glib preventor sits down feeling delightfully superior and enjoys the spectacle of the people on the podium struggling to get onside by professing their own undying admiration for prevention as well.

I wish preventors were a little less glib and a little more honest, a little more willing to admit that if prevention programs are going to have any real effect, they are going to require fundamental changes in the way we do things, not incremental changes.

For instance, the glib preventors would have us believe that if we would only fund enough alternative community clinics staffed with public health nurses, nutritionists, lifestyle counsellors, and what have you, then so-called lifestyle-associated diseases would be a thing of the past. Bye-bye heart disease, bye-bye liver disease, bye-bye pulmonary problems. Would that it were so.

The facts of the matter are that when John Q. Typical-citizen is suffering from a hangover and a bad case of tobacco-induced bronchitis, he doesn't want some sanctimonious Samaritan lecturing him about the deleterious effects of his junk-food diet and his self-destructive habits; he wants to see the Doc, get the Shot, and get the hell out of there. So he goes to the emergency room. He is not going to go down the hard path of Prevention as long as he can waltz down the street of Easy Cure.

That being the case, the only way you are going to influence his behavior — and hence his morbidity from behavior-related diseases — is to limit the available paths: that is, force him down the prevention path again and again for as long as it takes. Because, in the real world, an ounce of prevention isn't worth a pound of cure; you need to hit people over the head with a kilogram of prevention just to get their attention.

That's something the glib preventors tend to ignore. Just as they tend to ignore the fact that we could not develop truly effective prevention-oriented health-care institutions without structural changes in our health-care delivery system — changes so radical and so fundamental it is unlikely they would be politically palatable. For instance, if you're going to make prevention the main path, you have to close up the easy streets. At some point, you are going to have to tell people who persist in smoking that the state is not going to fund their heart by-pass operation when the time comes; and, you're going to have to tell the obese that they cannot get disability pensions as a reward for eating themselves immobile. And so on, and so forth.

Consider, for instance, the problem of the young drug user/abuser. It has been suggested that a teenager who is likely to develop a problem with drugs already has: (a) a parent with an alcohol or drug problem, (b) behavioral problems, (c) family conflicts, (d) low self-esteem, and (e) a record of poor school performance. If we are going to prevent drug abuse, then we have to prevent these things.

In practice, you cannot do that through the school system [where you could theoretically affect (d), (e), and possibly (b)], and you cannot do that through community clinics [where you could theoretically affect (a), (c), and possibly (b)].

In practice, if you hope to affect the incidence of teenage drug abuse you have to look at structural changes in our society; changes of such a radical nature they would be unacceptable to the vast majority of citizens. Change number one: a person with an alcohol or drug problem will not be permitted to become a parent. Change number two: married people who cannot demonstrate harmony and a lack of family conflict will not be permitted to become parents. And so on.

If we really want to make prevention more than a handy-dandy, all-purpose platitude, we are going to have to deal with issues such as these.

Needless to say, it isn't going to be as easy as the glib preventors would have us believe.

By Wayne Howell

Extradition treaty vital tool in fighting cocaine criminals

By Thomas Land

GENEVA — Drug enforcement officials from the United States and Colombia are involved in a high-level, diplomatic initiative aimed at restoring a recently suspended extradition treaty between the two countries.

The initiative is followed with great interest by many countries experiencing an upsurge in cocaine abuse. The treaty, which was recently declared unconstitutional and therefore invalid by the Colombian Supreme Court, is widely considered an essential legal weapon in the global war against the drug syndicates.

Colombia is one of the principal sources of cocaine flooding the black markets of North America and Western Europe.

The suspension of the treaty "represents a victory for the Colombian drug bosses in their continuing intimidation of legal and political figures at the highest levels," comments a diplomatic observer here. "It also illustrates the difficulties faced by both the Colombian and US officials in their fight against the drug trade."

The legality of the treaty was challenged on the grounds it was originally signed in 1980 not by the Colombian president — who was out of the country at that time — but by his deputy. To resolve the issue, President Birgilio Barco has signed the treaty again.

However, the court upheld the complaint, and the treaty provisions must now be approved by the Colombian Congress, where their passage may be blocked.

But, the treaty is vital, says a diplomatic report. Reprisals in the form of violent intimidation and the assassinations of key legal and political figures have marked attempts by Colombian authorities to deal with the issue.

In fact, the assassination of Justice Minister Rodrigo Lara in 1984 prompted the Colombian government to apply the treaty terms more vigorously. The first Colombians were extradited for trial in the US in January, 1985, under an order signed by Enrique Parejo Gonzalez, the next justice minister — who eventually survived an assassination attempt while serving as his country's ambassador to Hungary (**The Journal**, April).

The treaty proved useful in attacking the drug trade at its roots. Its effectiveness is assessed in terms of an offer made by Colombia's drug bosses in November, 1985, to repay the national debt of $13 billion in exchange for a revision of the treaty, as well as some related concessions.

Mr Parejo refused the offer. He told **The Journal** earlier this year: "There is not any possibility the government of Colombia can talk with narcotic drug traffickers. When I was minister of Justice, the government received a paper where the narco-traffickers said more or less the same thing."

Parejo: refusing the offer

A prominent newspaper and a political party have been established solely to fight the treaty. Attempts have been made to play on nationalist sentiments by describing the crime-fighting measure as an instrument providing for foreign interference in Colombian internal affairs.

Britain saying no go to ads urging drivers to 'Stay low'

LONDON — Britain is scrapping its drinking/driving advertising campaign and will use the money, about £10 million (Cdn $23 million) annually, on other measures more likely to save lives.

The move to end the decade-old ad campaign followed a report from the Department of Transport saying there is no proven link between the campaign and saving lives. The now-familiar slogans: "Think before you drink before you drive" and "Stay low" have failed to deter the hardened drunk-driving offenders, the report says.

The government has adopted the report's strategy. Transport Secretary Paul Channon said: "The immediate priority is to shift resources to actions which will save lives."

Safer roads and safer drivers will be the thrust. Transport officials believe one casualty a year can be saved for every £10,000 spent on road improvements. The same amount spent on advertising produces no measurable results.

New publicity efforts will aim at promoting editorial coverage of safety in newspapers and magazines.

Reaction to the announcement has been mixed. A spokesman for Alcohol Concern told the *London Sunday Times* the group was against the phasing out of the ads. "Publicity for drinking/driving is essential to educate the public," he said.

Medical campaigners, however, have welcomed the move. James Dunbar, MD, told *Doctor* efforts would be better spent on more random breath-testing and lifetime licence suspension for repeat offenders.

Students use fewer drugs, Australian research shows

ROZELLE, Australia — High school students are using fewer drugs — both licit and illicit — say researchers for the New South Wales Drug and Alcohol Authority.

"Large and significant" decreases were reported for use of licit drugs (alcohol, tobacco, analgesics, solvents, and aerosols) by the 6,168 students surveyed. Smaller, but still significant, declines were reported for opioids, stimulants, and illicit sedatives.

Marijuana was the only drug that did not show a significant decline, although there was a minor decrease, reports *Connexions*, published by the authority.

Highlights of the survey include:

- Tobacco — declines were most significant among female smokers. Now, at most ages, the smoking rates for both sexes are equivalent.
- Alcohol — although significant decreases were found in teen drinking, authorities are still concerned. Some 29% of 15 year olds reported drinking five or more drinks per occasion at least once in the two weeks prior to the survey.
- Analgesics — between 1% and 2% of students report daily use of analgesics.
- Marijuana — no major change was reported, but use appears to be "levelling off." It remains the most commonly used illicit drug, with 45% of 16-year-old males and 30% of 16-year-old females reporting having ever used marijuana.
- Solvents — the levels of reported use of solvents and aerosols were about half the 1983 survey figures, both in terms of those using and those who were experimenting.
- Other illicit drugs — only a small number of students report using heroin, cocaine, amphetamines, or illicit sedatives. But, up to 7% of 15- to 16-year-old students say they might try heroin if offered it by a trusted friend; as many as 15% said they might try cocaine in similar circumstances.

Ad in 'bad taste' running anyway

AUCKLAND, NZ — A drink-in-moderation advertisement showing young drinkers at a urinal is appearing on New Zealand television after being initially rejected.

The state-owned NZ television service had refused to show the ad because it was considered to be in bad taste.

The 30-second commercial, produced by the government-appointed Alcoholic Liquor Advisory Council, shows young men lamenting the money they had spent and the things they had missed out on in life through drinking.

INSIDE OUT

Through the fire — again

This is the end of the line, I thought, as I looked out over the river at the blinking night lights.

I'd been walking around the block, over and over again, because I was early. I'd also been walking because I was nervous about the upcoming event and excited and grateful I'd made it this far, safely, to the end of a long journey.

I had come through a blur of train rides and flights and a boat trip. I'd stayed in half-a-dozen hotels, a farmhouse, a splendid home in a bustling Swiss city, at a friend's apartment: I'd voyaged thousands of miles.

Like a kid again I was, a wanderer lost in a confusion of times and days and sudden lonelinesses, followed by the euphoria that comes from being stuffed with the contentment of pure freedom.

And here I was now. The time had come. I went upstairs in the church near the river in Paris, and I was overcome as I stepped inside.

The room was lovely, with windows looking out over the loveliest of cities. It was large and old with wooden bookshelves hugging the walls, and my first thought was: This feels like home. What was loveliest of all, of course, was the people sitting on the chairs — my brothers and sisters.

I'd wanted, before I came on this journey, to be part of a meeting somewhere at some time in Europe.

Sometimes, whenever I thought of AA (Alcoholics Anonymous), I had wondered about how its grand plan was being carried out around the globe, in places I'd never heard of, in languages too strange for my leaden mind to get a handle on.

The astounding fact of AA's near-universality had been reassuring to me somehow, when I planned the journey. I had read with wonder of a small AA group who'd gone to the Soviet Union, for the first time, to talk in a Moscow hotel room with Volodya, a 35-year-old alcoholic, about how to take one day at a time.

It wasn't that I was scared of the trip, scared I would fall down again because all the props of my life in Canada would be gone: I know that a falling down can happen anywhere, any time. But still it was good to know that even on faraway turf, there'd be someone to talk to. And the truth was that I had had a few scary moments anyhow . . . .

The meeting — it was for anglophones — was called to order.

This chapter, I learned, had been going on for decades in the City of Lights. One woman, astoundingly beautiful, spoke of her experiences to me. She was from the United States, living in Paris for more than three decades. She'd been coming to this chapter meeting since the mid-1950s. Another man, a Scot, had been coming for 11 years, I think he said.

But the chairman had just arrived a week ago, and the rest of us came from New York, from California, from all over the map.

We shared no common history, except for one major thing. Many of us would never see each other again, after this night.

Perhaps that explained the urgency: one young man walked out because of what he thought was a stupid bit of time-wasting protocol. He had come, he said fiercely, to get help to stay sober; if he couldn't get it, he was going to go.

But that flurry ended quickly as others stood up to speak of their despairs and their triumphs, and I had never been to a meeting like it. It was so naked, so passionate.

When the meeting ended and the people left to get their suitcases and their travel schedules, I walked around the block again, for good luck, before I went back to my hotel.

Tomorrow, I would be leaving to come home, and I thanked God for bringing me through the fire again.

Volodya and I — well, maybe we'll meet one of these days, and we won't need an interpreter.

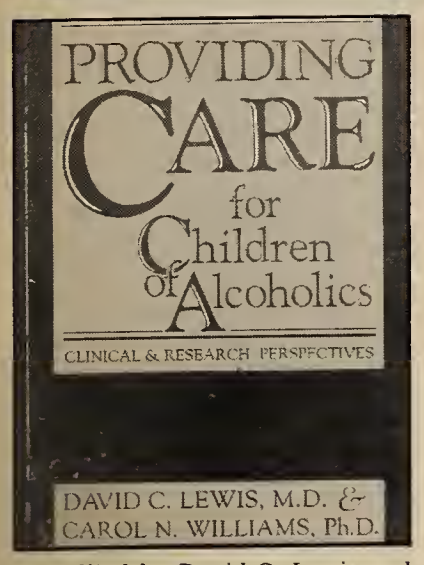
This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

Careers

REVIEWS

New Books

by Margy Chan*



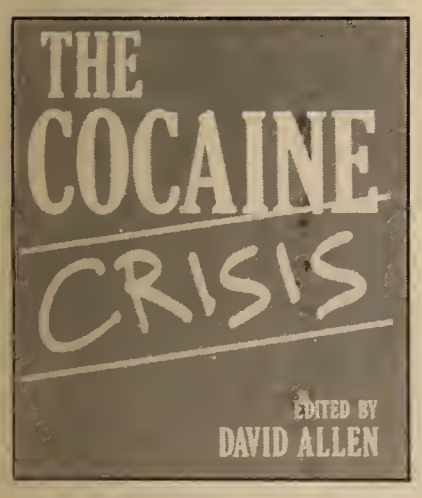
. . . edited by David C. Lewis and Carol N. Williams

Issues surrounding children of alcoholics have recently received considerable attention. Treatment and prevention programs are now beginning to address the needs of this special population. This is a timely book, taking clinical and research approaches to the problem.

This collection of papers represents diverse viewpoints. The multidisciplinary treatment of the topic covers: social and cultural factors in families with alcohol-related problems; child development and alcoholism; fetal alcohol syndrome; familial patterns of alcoholism; children of alcoholic families; clinical interventions; and, public policy issues.

A monograph is included from the Center of Alcohol Studies, Brown University, Providence, Rhode Island.

Health Communications, Pompano Beach, Florida. 112p. ISBN 0-932194-34-6.



. . edited by David Allen

This book is based on the proceedings of the 1st International Cocaine Symposium, November, 1985, in the Bahamas and co-sponsored by the United States embassy and the Bahamian government. The goal of the conference was to share experiences and knowledge to improve the management and treatment of cocaine addicts.

Experts from South America, the Caribbean, and the US presented different aspects of the problem found in their countries.

The book begins with a general introduction of the problem and overview of major issues. The section on US experiences focuses on those problems associated with a large, consumer society. The Caribbean countries, as trans-shipment centres between South and North America, also have problems. The South American presenters, as representatives of producer-countries, focus on experiences with coca-paste addiction. The book concludes with a socio-ethical perspective of the problem.

Plenum Publishing, New York, NY 1987. 235p. $49.50. ISBN 0-306-42482-7.

Books Received

The Success Syndrome: Hitting Bottom When You Reach the Top — Steven Berglas, Plenum Press, New York, 1980. 289p. $18.95. ISBN 0-306-42349-9.

Living Hungry in America — by J. Larry Brown and H.F. Pizer, MacMillan Publishing Company, New York, 1987. 212p. $18.95. ISBN 0-02-517290-5.

**Margy Chan is manager of the Addiction Research Foundation's library, the leading library in the field worldwide. A graduate of the University of Hong Kong, she holds a master's in library science from the University of Toronto.*

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ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Just Another Friday Night

Number: 808.
Subject heading: Impaired driving; trigger film.
Time: 15 min.
Synopsis: John, an 18 year old, is sitting in a courtroom as his lawyer and the prosecution present final arguments and sentencing recommendations to the judge. John's lawyer asks for leniency in the form of a drinking-driving course; the prosecutor asks for a lengthy jail sentence. While the judge considers the case, events leading up to the accident are re-enacted. John left work, bought beer, and went to pick up friends. They piled into John's truck heading for a party. Everyone was drinking and urging John to drive faster. John lost control of the truck, and eight friends were killed. Back in court, the judge demands that John tell him what judgment should be rendered.
General evaluation: Good to very good (4.5). This contemporary, well-produced film could lead to good discussion about culpability for accidents and everyone's responsibility for the prevention of drinking and driving. Allowing the audience to decide the sentence is an excellent way to spark discussion. General broadcast is recommended.
Recommended use: With a resource person, this film would benefit general audiences, especially those 12 to 18 years of age.

Inside EAP

Number: 811.
Subject heading: Employee assistance programs (EAPs).
Time: 18 min.
Synopsis: A woman is having trouble on the job; she is often late or absent. Her husband, who works in the same hospital, is also having trouble. The woman realizes she needs to do something and goes to the hospital EAP counsellor. Her husband has an alcohol problem, but she needs help just as much as he does. Hospital staff role-play different scenarios that could lead to EAP referrals. Both husband and wife get help and return to work.
General evaluation: Good (4.0). This film shows many good aspects of the use of EAPs; however, there appears to be a breach of confidentiality by an EAP worker in the film.
Recommended use: With a resource person, this film would be of benefit in supervisor training.

Don't Drive Drunk

Number: 809.
Subject heading: Impaired driving; rock video.
Time: 5 min.
Synopsis: Stevie Wonder performs a song about not driving drunk. Mark goes into the nightclub and drinks heavily; when he decides to drive home, his friends try to dissuade him. Mr Wonder comes out of the club and tells Mark to give the car keys to his friends.
General evaluation: Good to very good (4.5). This is a good trigger film which could spark discussion on ways to deal with drinking drivers. General broadcast is recommended.
Recommended use: With a resource person, this video would benefit those 12 to 18 years of age.

Cocaine and the Brain

Number: 812.
Subject heading: Cocaine.
Time: 30 min.
Synopsis: After several years of treating cocaine abusers and to improve treatment, a therapy centre interviews patients and develops a "biological" theory to explain the 'out of control' feeling commonly expressed by cocaine-using patients. Understanding the specific stages of cocaine addiction and the accompanying neurophysiological processes aids understanding of patients and their effective treatment.
General evaluation: Poor (2.4). This lecture is boring and repetitive. It is also difficult to see the visuals.
Recommended use: With an expert resource person, this film could be used by health professionals.

Recovery from Cocaine Addiction

Number: 813.
Subject heading: Cocaine: treatment/rehabilitation.
Time: 30 min.
Synopsis: Early treatment of cocaine users relied on medication, but a study shows the majority relapse. It is important to understand the brain chemistry to understand cocaine addiction and thus know the best treatment method. Many cocaine users also use alcohol; this must be considered in treatment. The lecturer outlines stages of recovery and how to handle patients at each.
General evaluation: Poor (2.0). This film is too long and boring.
Recommended use: With a resource person, this film could be used with health professionals.

Just a Little Problem

Number: 810.
Subject heading: Employee assistance programs (EAPs).
Time: 8 min.
Synopsis: In this animated film, everything goes along fine for Joe until, one day, he feels a little "nudge." This little nudge goes everywhere with him and occupies his thoughts. He doesn't want anyone to know about the nudge and spends more time trying to hide it than doing his job. The nudge gets bigger and bigger until one day Joe realizes it's not going to go away on its own; he needs help. He goes to a counsellor and, with others, discusses the problem, works at understanding it, and slowly the nudge begins to shrink.
General evaluation: Fair (3.3). This short film effectively and briefly conveys the concept of EAPs and could lead to discussion about the need for one and the use of a self-referral system.
Recommended use: With a resource person, this film could be used with workers and management to introduce the EAP concept.

What Everyone Should Know About Alcohol

Number: 802.
Subject heading: Alcohol/alcoholism overview.
Time: 19 min.
Synopsis: The audience is asked a series of questions about alcohol; animated characters illustrate each question, and people on the street give answers. Three alcohol experts explain the correct responses.
General evaluation: Good to very good (4.6). The film is a lighthearted way to give good information that can be easily understood by general audiences. Animation sequences are especially well done. The discussion of alcohol effects makes no distinction between men and women, however, and there is some confusion over the definition of a standard drink. General broadcast is recommended.
Recommended use: With a resource person who could discuss gender differences associated with alcohol, the film could benefit general audiences.

CONFERENCES

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Covenant House 2nd Symposium on Street Youth — Nov 2-4, Toronto, Ontario. Information: Covenant House Toronto, symposium office, 70 Gerrard St E, Toronto, ON M5B 1G6.

Children of Alcoholics: Turning the Corner — Nov 5, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Tomorrow's Youth Today — Nov 11-13, Collingwood, Ontario. Information: Lise Labrecque, conference coordinator, 74 Hurontario St, Unit 1, Collingwood, ON L9Y 2L8.

Public Forum: Drug Use and AIDS — Nov 12, Toronto, Ontario. Information: Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Canadian Conference on AIDS Education — Nov 12-13, Cornwall, Ontario. Information: John Darbyshire, Eastern Ontario Health Unit, 1000 Pitt St, Cornwall, ON K6J 3S5.

Drug, Alcohol, and Stress Problems in the Health Professions — Nov 13, Toronto, Ontario. Information: Michel Chevalier, executive director, Ontario Health Professionals Assistance Program Inc, 133 Richmond St W, Ste 501, Toronto, ON M5H 2L3.

The Psychiatric Patient in Crisis: Strategies for Intervention — Nov 19, Toronto, Ontario. Information: Nancy Forbes, Education Services, Queen Street Mental Health Centre, 1001 Queen St. W, Toronto, ON M6J 1H4.

Alcoholics Anonymous Workshop: How to Use the Self-Help Process — Nov 23-24, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

From Addiction to Addiction-Free Lifestyle — Nov 27, Toronto, Ontario. Information: Linda Sanders, Humber Memorial Hospital alcohol unit, 200 Church St, Weston, ON M9N 1N8.

Countermeasures 87 — Dec 6-8, Toronto, Ontario. Information: Countermeasures 87 conference, Drinking/Driving Countermeasures office, Ministry of the Attorney-General, 10 King St E, 8th fl, Toronto ON M5C 1C3.

Toc Alpha's 31st Annual Christmas Conference — Dec 27-30, Toronto, Ontario. Information: Michelle Amez and Michael DeGagne, Toc Alpha/ Alcohol and Drug Concerns, 11 Progress Ave, Scarborough, ON M1P 4S7.

Pharmacology and Drug Abuse — Jan-April, 1988, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Fundamental Concepts Distance Education Course — Jan 26-April 19, 1988, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Canadian Society of Hospital Pharmacists, Professional Practice Conference — Feb 1-5, 1988, Toronto, Ontario. Information: Barbara Cole, 123 Edward St, Ste 603, Toronto, ON M5G 1E2.

Connections 88 — Feb 8-10, 1988, Saskatoon, Saskachewan. Information: Saskatchewan Health Research Board, #5, 3002 Louise St, Saskatoon, SK S7J 3L8.

41st Annual Meeting Ontario Psychological Association — Feb 11-13, 1988, Toronto, Ontario. Information: Yonet Schroder, executive assistant OPA, 730 Yonge St, Ste 221, Toronto, ON M4X 2B7.

Cocaine Abuse: Clinical Issues — April 25-26, 1988, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

88th Annual Conference Canadian Lung Association — June 2-5, 1988, St John's, Newfoundland. Information: A. Les McDonald, director, health education and program services, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

108th Annual Meeting Ontario Medical Association — June 6-10, Toronto, Ontario. Information: Erna Walker or Heather L. Smith, Ste 600, 250 Bloor St E, Toronto, ON.

Institute on Addictions — Bridging the Gaps: Law Enforcement, Communities, Helping Agencies — July 3-6, 1988, Calgary, Alberta. Information: Tom Wispinski, institute chairman, Alberta Alcohol and Drug Abuse Commission, 7th fl, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Florida Association of Alcoholism and Drug Abuse Counsellors 1st Statewide Conference — Nov 6-8, West Palm Beach, Florida. Information: FAADAC, president Larry Osmonson, c/o ANABASIS, 1045 S Briggs, Sarasota, FL 33577.

AIDS and Chemical Dependency: Multidisciplinary Approaches — Nov 7-8, San Francisco, California. Information: Mim Landry, Haight-Ashbury education group, 409 Clayton St, San Francisco, CA 94117.

Association for Medical Education and Research in Substance Abuse Annual Meeting — Nov 10-13, Washington, DC. Information: AMERSA conference coordinator, Center for Alcohol and Addiction Studies, Brown University, Box G, Providence, Rhode Island 02912.

University of California, San Diego (UCSD) Extension Program on Alcohol Issues — Nov 10-13, San Diego, California. Information: Tom Colthurst, program on alcohol issues, UCSD X-001, La Jolla, CA 92093.

2nd Western Regional Conference — Nov 11-13, San Francisco, California. Information: National Association of Student Assistance Programs and Professionals, Box 3148, Oakton, Virginia 22124.

Association for the Advancement of Behavior Therapy Annual Meeting — Nov 12-15, Boston, Massachusetts. Information: Mary Jane Eimer, executive director, 15 W 36th St, New York, NY 10018.

Triple Threat: Alcohol, Other Drugs, and Post Traumatic Stress Disorder — Nov 13-14, La Jolla, California. Information: Alcohol and Other Drug Studies, University of California, San Diego X-001, La Jolla, CA 92093.

Young Children of Alcoholics: From Neglect to Discovery, Intervention to Recovery — Nov 14, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, 435 Hawthorne Ave, Oakland, CA 94609.

Recovery Workshop for Adult Children of Alcoholics and Other Adult Children of Trauma — Nov 16, Santa Barbara, California. Information: Herb Gravitz, 5266 Hollister Ave, Ste 220, Santa Barbara, CA 93111.

Alcohol and Drug Abuse Prevention Symposium: Create the Spirit of Family — Nov 16-18, Anchorage, Alaska. Information: Marcia Michel, symposium coordinator, Alaska Council on Prevention of Alcohol and Drug Abuse, 7521 Old Seward Hwy, Ste B, Anchorage, AK 99518.

2nd Annual Southeastern US Regional Conference on Adult Children of Alcoholics — Nov 19-22, Atlanta, Georgia. Information: US Journal Training, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Southeastern Conference on Alcohol and Drugs 1987 — Dec 2-6, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease division, Box 209, Ste 701, Macon, GA 31298.

Pacific Institute of Chemical Dependency — Jan 4-16, 1988, Honolulu, Hawaii. Information: Joyce Ingram-Chinn, Alcohol and Drug Abuse branch, Box 3378, Honolulu, HI 96801.

Treatment of Addictive Disorders: 14th Annual Advanced International Winter Symposium — Jan 31-Feb 5, 1988, Colorado Springs, Colorado. Information: Gary G. Forrest, Psychotherapy Associates, 3208 N Academy Blvd, Ste 160, Colorado Springs, CO 80917.

9th Annual Training Institute on Addictions — Feb 4-9, 1988, Clearwater Beach, Florida. Information: Institute for Integral Development, Box 2172, Colorado Springs, Colorado 80901.

2nd National Forum on AIDS and Chemical Dependency — Feb 18-20, 1988, Phoenix, Arizona. Information: Conference information, Box 81691, Atlanta, Georgia 30366.

American Orthopsychiatric Association (ORTHO): Adapting to Social Change, Therapy, Technology, and Services — March 27-31, 1988, San Francisco, California. Information: ORTHO, 19 W 44th St, Ste 1616, New York, NY 10036.

National Association of Student Assistance Programs and Professionals 3rd Annual Conference — May 1-4, 1988, Chicago, Illinois. Information: US National Association of Student Assistance Programs and Professionals, Box 3148, Oakton, Virginia 22124.

Abroad

6th World Conference on Smoking and Health — Nov 9-12, Tokyo, Japan. Information: Japan Convention Services Inc, Nippon Press Center Bldg, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan.

Alcoholism and Other Dependencies — Nov 22-25, Warsaw, Poland. Information: C. Godwod-Sikorska, Institute of Psychiatry and Neurology, Sobieskiego 1-9, PL-02-957 Warsaw, Poland.

9th International Conference of Non-Governmental Organizations for the Prevention of Drug and Substance Abuse — Nov 23-27, Hong Kong. Information: Conference secretary, 9th NGO conference, c/o Hong Kong Council of Social Service. GPO Box 474, Hong Kong.

International Conference on Alcohol and Industry — Dec 3-5, Medellin, Colombia. Information: SURGIR and International Council on Alcohol and Addictions, Apdo. Aereo 10199, Medellin, Colombia.

11th World Conference of Therapeutic Communities — Feb 21-26, 1988, Bangkok, Thailand. Information: Justice Amnuay Intuputi, chairman, organizing committee, Non-Government Organization, Anti-Narcotics Coordinating Centre, National Council on Social Welfare of Thailand, 257 Rajvithi Rd, Bangkok, 10400, Thailand.

1st International Conference on the Global Impact of AIDS — March 8-10, 1988, London, England. Information: Conf ZZ, Emap Maclaren Exhibitions Ltd, Box 138, Token House, 79-81 High St, Croyden CR9 3SS, England.

35th International Congress on Alcoholism and Drug Dependence — July 31-Aug 6, 1988, Oslo, Norway. Information: International Council on Alcohol and Addictions, case postale 189, 1001 Lausanne, Switzerland.

Motherisk — fighting the misconceptions

By Betty Lou Lee

TORONTO — It was the tragedy of the decade: babies born with tiny flippers instead of arms, with stumps of legs, without ears. The name thalidomide was not only acid-etched in the minds of women, but so was the realization that they could affect the development of their babies by substances they took during pregnancy.

That has been reinforced by subsequent headlines: fetal alcohol syndrome, smaller babies from smoking mothers, addicted babies from heroin addicts, as well as congenital malformations from a variety of medications.

The result has been that many women now overestimate the chances of damage to their babies from something they have taken, often before they realized they were pregnant, and are unnecessarily choosing abortion.

Motherisk, a service of the division of clinical pharmacology, Hospital for Sick Children, Toronto, is now fielding 100 phone calls a week from worried women wondering what effect medication, alcohol, illicit drugs, or workplace situations may have on their babies. Some queries are as uncomplicated as whether it's safe for the baby if the mother exposes herself to paint fumes by painting the nursery. (The answer is yes.)

Up to 15 women will attend the clinic the same week for a personalized assessment of their risks.

"We believe a large number of pregnancy terminations are based on misinformation. It's a large public health problem," says Gideon Koren, MD, director of Motherisk and an assistant professor of pediatrics and pharmacology, University of Toronto.

"Their perception of risk is often based on what was told them by their doctors or their mothers-in-law, and most assign a risk that is unrealistically high — often 10 times the actual risk. Some women exposed to a nonteratogen (an agent that poses no risk to the embryo) assign a risk of 25%, which was the risk of thalidomide. No wonder many of them think of abortion.

"Cocaine is a very big public issue. But all the studies (of its effect on the baby) have been done with addicts who took it throughout pregnancy. Many of them were intravenous users with poor nutrition, repeated infections, and were smoking and drinking a lot.

"Of more than 15 studies with addicts, none showed an increased risk for major malformations," although the children may have developmental problems, he added.

These data can't be extrapolated to women who used the drug occasionally and stopped as soon as they knew they were pregnant, Dr Koren said, yet these women are "prone to terminate their pregnancies."

A similar situation exists with fetal alcohol syndrome (FAS).

"The real adverse effects of FAS have been found only in heavy drinkers, those who had five to seven drinks a day in the first trimester. Even then the risk is 10%, not 50% as some think. Some casual drinkers are horrified because they didn't know they were pregnant. I know in some cases we avoided terminations (abortions.)"

'Their perception of risk is often what is told them by their doctors or mothers-in-law'

Heather Graham

To say, as many scientists do, that "it's better for the baby if the mother doesn't drink," is "a safe statement, but not scientifically valid," says Dr Koren.

"We can't say any dose will cause something. We don't know if there are effects at lower levels. No one has proven yet that less than one drink a day is capable of causing fetal alcohol syndrome or any other defect. But I don't say there isn't some effect."

Benzodiazepines are another big worry for pregnant women.

"In the 1970s, there were some studies that linked them to cleft palate, and some women think the risk is 40% to 50%. The risk (of clefting) in the general population is one in 1,000, and even if you believe these studies, the risk is three in 1,000 — and that's for a treatable defect that doesn't affect the brain. We don't believe it causes clefts, based on the available data."

The Motherisk team that meets weekly to discuss patients and new scientific data includes medical experts in toxicology, genetics, pharmacology, pediatrics, and obstetrics.

They crystallize a clinical approach after assessing the hundreds of animal studies, case reports, and human studies that are published every year and have drawn up statements on about 300 drugs and chemicals.

About half the women who call on their own or are referred by their doctors are worried about some inadvertent exposure to drugs, usually before they knew they were pregnant. Another quarter have questions about therapeutic use of drugs in pregnancy for conditions such as migraine or epilepsy.

The rest are concerned about radiation or chemical exposure, are seeking possible causes of an abnormality in a child already born, or are considering pregnancy and want advice.

Those who are already pregnant are seen in the Friday clinic the same week they call, but in case of emergencies, even holiday service is available.

All possible factors are assessed: obstetrical history, genetic background, medical problems, and all drug and chemical exposures during pregnancy, including smoking and drinking patterns.

The women are then told about the available data, how this can be interpreted in terms of their personal risk, and how this relates to baseline risk in the general population. "We try to put things in perspective, not create fear," explains Dr Koren.

"We never recommend abortion. We tell people what is known. We have no estimate of the terminations we've prevented, but we know the percentage isn't negligible. At least one woman a week we see has already booked one, or is seriously considering it."

Of the 320 women seen in the clinic's first year, only four (1.3%) decided on an abortion based on information given them. Of the 601 drugs and/or chemicals they had been exposed to, 163 (27%) were known or suspected teratogens.

Two women chose abortion because of exposure to Accutane (isotretinoin), a drug for severe acne which carries a 40% risk of malformation, significantly higher than the 25% risk for thalidomide.

"The same risk may be perceived differently by different women," Dr Koren notes.

An epileptic taking the anti-convulsive drug Dilantin (phenytoin) throughout pregnancy, for example, runs about a 10% chance of a major malformation in her baby — three times the risk of the general population. Some are willing to accept anything under a 50% chance; others won't take any chance.

"It's not up to us to decide what's too high," says Dr Koren. Sometimes alterations in medications can be suggested, such as a different drug or different dosage.

If additional tests like ultrasound or amniocentesis are indicated, they are arranged during the clinic visit. A letter is sent to the patient's doctor even if she referred herself to the clinic.

Smokers are referred to stop-smoking programs if they are interested.

Dr Koren says smoking has been shown to increase the risk of premature birth and smaller babies, and animal studies have shown that carbon monoxide levels that don't affect the mother may affect the fetal brain.

Satellite clinics have been established with genetics nurses in North Bay, Sudbury, and Peterborough, who can use telephone consultations with Toronto. Clinics are also being established in London and Ottawa by two former graduate students who received training at Motherisk.

Assessments of all children born to mothers seen at the clinic or served by its satellites are now being done in the child's first year by team pediatricians.

In the case of some new drugs or chemicals on which little information exists, a more detailed developmental assessment is done.

The congenital malformation rate among patients is running at 5% to 6%, compared to 3% to 5% for the general population.

Dr Koren says that although about 20 hot-line telephone information services exist in the United States, he knows of only one, in Utah, that provides a personalized assessment in a clinic. He knows of none outside Ontario in Canada.

In future, he hopes to conduct a scientific study among non-pregnant women on what they believe to be the fetal risks of various drugs and chemicals and the sources of their information or misinformation.

"We know in many cases it was the lay press. But also in many cases, doctors have advised women to terminate. There's a huge misconception in the general public.

"The approach seems to be that everything is dangerous until proven that it's not, when the real situation is just the opposite."

THE BACK PAGE

Stamler: power and money

Drug crime networks extend to prisons

By Joan Hollobon

TORONTO — Major criminals are running illicit drug operations from their jail cells, and the Canadian system is powerless to prevent that until the law allows seizures of the proceeds of crime, says Chief Superintendent Rodney T. Stamler.

Drug Enforcement Directorate chief, Royal Canadian Mounted Police (RCMP), Chief Supt Stamler was speaking here to the 5th annual conference of the Drug Education Coordinating Council.

His remarks came in response to the question: is organized crime running the prison system?

"I won't say every prison is run by organized criminals. I would say that certainly it (the system) is influenced greatly, and the activities are influenced. . . .

"I think in Canada from time to time, major organized criminals go to jail, and they continue to run their operations from that particular jail.

"You can't stop their interactions with the community through visitors and so on; our system won't permit it. And so they have influence from the outside, they have power and money, and that translates into power inside. They can extort situations from both guards and other prisoners."

He said the only effective control is to deprive the criminal of his power by confiscating the profits from criminal activity: "As long as he has the money, he has the power; he can control no matter where he is."

Superintendent Sefrin Ginther, RCMP officer-in-charge of the Ontario drug enforcement branch, recalled an incident in which a jailed crime figure, acting through his family, actually expanded his business, particularly in heroin, while serving a 17-year prison sentence. The criminal gave his orders through his son, who visited him four times a year.

Chief Supt Stamler described the worldwide networks involved in production and distribution of illic-

(See Cash, p2)

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Study monitors 115 sero-positive IV users and partners

HIV infectivity hiatus uncovered

By Harvey McConnell

EDINBURGH — Intravenous drug users infected with HIV virus go through a phase during which they apparently do not pass on the virus by either sexual contact or needle sharing.

This is the profound conclusion being drawn by Roy Robertson, MD, and colleagues, who are continuously monitoring 115 sero-positive patients, their sexual partners, and many of their family members who live in the Muirhouse housing estate here.

Dr Robertson was besieged by the media in February, 1986, when he announced that the 51% HIV-positive rate among more than 200 intravenous (IV) drug users on the estate was the highest in Western Europe and approached levels being found in New York City.

Muirhouse allows for a unique case-controlled study of the natural history of AIDS among IV drug users. Almost all of the 17,000 residents of the estate are patients of Dr Robertson and 10 fellow general practitioners, who, from their large clinic, offer a complete spectrum of medical services under Britain's National Health Service. Almost all of the drug users were born on the estate or are long-time residents; their medical histories are on file.

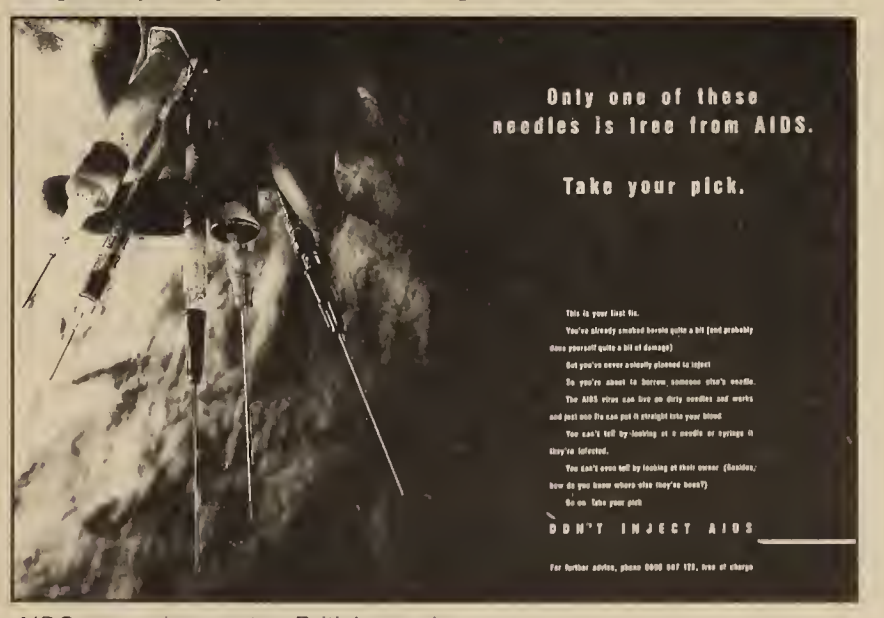
Heroin use suddenly exploded on the estate, and in other parts of Edinburgh and Dundee, in the early 1980s; by 1984, the first case of HIV infection was discovered at Muirhouse. Doctors believe they can identify the index patient who introduced the virus.

In the past year, there has been a dramatic drop in needle-sharing, but little change in unprotected sexual intercourse as shown by the high pregnancy rate and the cultural disdain for condoms.

Dr Robertson and psychologist Carol Skidmore, who directs the study, constantly update their computerized data bank and work closely with virologists at Edinburgh City Hospital and Edinburgh University, who use the ELISA and Western Blot assays for detecting the HIV virus.

Sexual contacts of the HIV-positive patients are monitored every three months for presence of the virus. In many cases, dates of sero-conversion can be pinpointed within weeks.

In one family, four siblings are all IV drug users and share needles: one female and one male are HIV-positive, and two males are HIV-negative. One of the HIV-negative siblings, however, displays some of the symptoms of AIDS related complex (ARC): enlarged glands, thrush infection, and low T4 killer cell counts. His wife is also sero-negative.



AIDS campaign poster: British warning

In another family, two brothers are IV drug users and share their needles: one is HIV-positive and one HIV-negative.

A 16-year-old girl who is sero-negative lives with her boyfriend who is a sero-positive IV drug user. She has given birth to a sero-negative infant and is pregnant again.

The first case of AIDS on the estate was diagnosed in October, and doctors believe up to 40 people there are now displaying ARC symptoms.

Dr Robertson has been in contact with leading virologists in Britain and North America for their opinions of why so many people in intimate contact with HIV-positive patients have not sero-converted, "and they just don't know. I don't think anybody knows."

The pattern at Muirhouse probably ties in with the natural history of AIDS: "I think the people who have got it sexually and through needle sharing got it at a time from people who were highly infectious — before they went through a phase when they are less infectious.

"We are beginning to accept now

(See HIV, p2)

AIDS: a community case study p7

Med students admit drug problems

It is incumbent on all schools to offer help

By Harvey McConnell

WASHINGTON — Eight per cent of students at a leading United States medical school report they have a major alcohol or other drug problem.

Two of the students have used cocaine at least 100 times while in medical school, and one is using cocaine while taking care of patients, says Richard Schwartz, MD, clinical professor at the Childrens Hospital National Medical Center.

The findings emerged from a study of attitudes and drug use among 270 medical students. Results were presented by Nicholas Kyriazi, a final-year medical student, and Dr Schwartz, study director, at the Association for Medical Education and Research in Substance Abuse conference here.

Dr Schwartz said the study guaranteed complete anonymity, had no direct involvement of the school administration, used a questionnaire devised with David Lewis, MD, Brown University, and was analyzed independently by Norman Hoffmann, PhD, of the Chemical Abuse/Addiction Treatment Outcome Registry in Minneapolis.

Dr Schwartz commented that findings that around 8% of students reported alcohol and other drug problems correlates with studies in the general population. "However, because of the clinical decision-making (future) doctors are going to need, and split-second decision-making when a patient's life could be at stake, there should be a higher level of accountability."

He believes the problems found by the study exist in most other large medical schools. He said there is a responsibility for medical schools to accept there are problems with some students and to put in place student assistance programs to identify, intervene, and manage students "without sweeping the problem under the carpet or sending the students away."

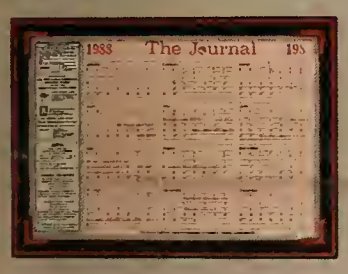
It is incumbent on medical schools "not to send impaired doctors out into the community."

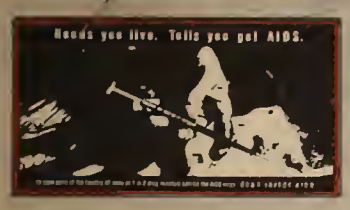
There was a statistically significant association between students' drug use and attitudes supporting legalization of marijuana and private occasional adult use of cocaine. Among all students, 67% rated the department of pharmacology as excellent to very good in teaching about substance abuse, compared with a 23% rating for the department of psychiatry.

Britain to extend pub hours

page 3

INSIDE





NEWS

Briefly . . .

Fair comment

TORONTO — Tobacco companies make good sponsors and should stay, says a staff report from the Canadian National Exhibition. In fact, "they've acted as good corporate citizens," giving more than $150,000 for events last year and operating information kiosks at the fair, worth another $100,000, says a report in *The Toronto Star.*

Dog days

LANSING, Michigan — Some United States companies have turned away from urinalysis drug screening and are now using canine-search techniques. Drug-sniffing dogs are a less invasive, more reliable method of detecting drug using employees, says *Monday Morning Report.* Critics call canine searches a Rambo-style invasion of privacy and warn dogs too can make mistakes, reacting to cough syrup as marijuana and to birth control pills as other contraband.

Candy controversy

BRIDGETON, Missouri — A United States volunteer agency hopes to halt the sale of liquor-filled candy to children. An article in *The American Issue,* newsletter of the American Council on Alcohol Problems, says the candy, wrapped in foil and molded to resemble either a barrel or liquor bottle, costs as little as 50 cents a piece. It can contain up to 13.6% alcohol by volume, more than three times as potent as US beer and stronger than most table wines. John Jay, chairman of the US National Organization Against Liquor in Candy for Children (NO-ALCC), says the candy should be sold only in outlets where other alcoholic products are sold and should be regulated by the state.

Welsh thirst

LONDON — Alcohol consumption in Wales is 25% higher than in England, and one in four men more than 18 years old drink at hazardous levels, reports the newly formed Welsh Health Promotion Authority. Protesting a plan to extend pub hours (see page 3), the authority also reports the Welsh liver cirrhosis death rate is 23% higher than in England and one in five 11- to 12-year-old boys in Wales have been drunk at least twice. *Doctor* says an Authority survey found 54% of the population is opposed to extended pub hours.

Grandfatherly advice

WASHINGTON — Senior-citizen volunteers will be teamed with young drug users and other troubled teens in a $2.5 million pilot program aimed at giving individual attention to at-risk youth. ACTION, a United States federal domestic volunteer agency, has received endorsement from Mrs Nancy Reagan and funding from the US government to increase services to youth through their Foster Grandparents Program, the Retired Senior Volunteer Program, and the ACTION Drug Alliance. Grants will also sponsor training conferences and drug-prevention education programs.

Needle exchange needed in Canada

By Peter Unwin

TORONTO — Aggressive, street-level counselling about needle-cleaning is essential if Canada is to escape the high rates of HIV infection found among intravenous (IV) drug users in other parts of the world.

And, Canada must either accept, or have a very good reason for rejecting, promotion of needle and syringe exchanges.

"I don't think we can ignore it any longer," James Rankin, head of medicine and physician-in-chief of Ontario's Addiction Research Foundation (ARF), told an ARF-sponsored public forum here on AIDS and drug use.

He said Canadian IV drug users are already very knowledgeable about the dangers of sharing needles, but they still continue to share. "If they had gone through an education program, they would have gotten an honors pass in terms of their knowledge of AIDS and its transmission," Dr Rankin said.

"All we have to do is wait long enough and we can also have 80% or 90% infection among IV drug users. It really is a question of how long we wait."

Dr Rankin said needle and syringe exchanges have now been accepted by some governments "... even in conservative Australia. Not all of these programs are government-sponsored, but they are certainly accepted by government.

"The evidence would indicate this sort of program does not increase syringe or needle use; it seems to relate to more people coming into treatment. It also appears to be related to a decrease in drug-taking behavior.

"I don't think if we make syringes and needles available on exchange, the drug problem will grow," Dr Rankin said.

While the percentage of Canadian IV drug users with AIDS is small compared to other countries (0.4% in Canada, compared to 16% in the United States), "we know there are at least 1,000 people in Canada on methadone for treatment of heroin dependence. If we speculate (that) at best only one in 10 heroin-dependent people is in methadone treatment, that would extrapolate to 10,000 people who are heroin dependent."

The federal Bureau of Dangerous Drugs estimates there are 17,700 chronic narcotic users in Canada. Many inject not only heroin, but also other drugs, including cocaine.

Dr Rankin: "We do have shooting galleries (where addicts meet to inject drugs) in Toronto; we do have shooting galleries elsewhere in Canada. We know from discussion with our patients here they do share needles and syringes, and they do it fairly commonly. . . . We also know they are involved with multiple sexual partners."

Dr Rankin urged that attention also be paid to other special groups: prison inmates; homeless youth, particularly in large centres: and, those who experience barriers to treatment because of their language problems or low levels of literacy.

HIV: women playing 'Russian roulette'

(from page 1)
that during the middle phase, after sero-conversion and before people get ill, they appear to be non-infectious, and they can't pass the virus sexually. Later on, when they begin to express antigen again, when their lymphocyte cultures become positive, they are obviously again infectious, and they are going to pass it on.

"Thus, we may have a bi-phasic illness. In Edinburgh, we have seen the first phase, and we are now in the middle phase where we have a lot of non-infectious people, and therefore we don't have many sero-conversions by others.

"But, we may well get another wave of infection in six months' time."

Additional evidence for the theory was provided in late October when a virologist-collaborator isolated the HIV virus from a woman whose boyfriend had just developed the symptoms of ARC.

Ms Skidmore: "She has not yet developed antibodies which can be picked up by the usual tests, but it is most likely she is about to sero-convert, and it is too late to do anything for her.

"We have a series of female sexual contacts who do not seem to be catching the virus, but we think there is a limit to how long they can continue to be negative. They are playing Russian roulette."

Robertson: T4 cell status

Dr Robertson says the clinical findings do not support the contention by some that heroin might be an immunosuppressive: "We are finding that T4 cell status in the sero-positives is the same whether they are still injecting heroin or whether they have been abstinent for a long period of time."

The next step is to administer AZT (azidothymidine, also called zidovudine [**The Journal**, July]) to sero-positive patients to see if it retards or prevents their conversion to ARC.

"For a long time we have been trying to pressure the United States National Institute on Drug Abuse and the Centers for Disease Control to include us in their sero-positive studies; that really has come to nothing. However, there is a United Kingdom initiative coordinated by the Medical Research Council and Oxford University, which hopes to enroll 2,000 sero-positive patients in the next 12 months.

"It's going to be enormously difficult, of course, to know when people sero-converted, and thus, to know whether or not AZT is working."

The index patient thought to have introduced the virus to Muirhouse is a young woman IV drug user tested at the clinic in June, 1983 for hepatitis and tested again in Newcastle in September, 1983. Both samples were stored; retests in 1984 found she was HIV-negative in June, but HIV-positive in September.

Ironically, during the same period, her brother had moved to Oxford and shared needles with a large group of IV drug users, including a number of students at the university, one of whom was a homosexual hemophiliac.

Kids, drugs — use down

TORONTO — A study by Ontario's Addiction Research Foundation of 4,267 Ontario students has found that use of 17 drugs continues to drop, especially use of cannabis, barbiturates, and stimulants.

Reginald Smart, PhD, director of prevention studies, said significant declines in cannabis use in Metropolitan Toronto and Western Ontario indicate an important trend as cannabis is the most widely used illicit substance.

Full report in The Journal next month.

Cash for distribution plan arrives with marijuana load

(from page 1)
it drugs and in the highly sophisticated laundering of profits through the international banking system.

There are now an estimated 100,000 to 500,000 cocaine users in Canada, and cocaine is becoming the second most popular drug after cannabis, he said. There are more than 500,000 chemical users, and possibly two million cannabis users. Billions of dollars in profits are going through multi-cultural networks to fuel production in Thailand, Pakistan, South-West Asia, and South America.

Eight tons of Thai marijuana that entered Canada recently would have been worth $8 million on the street. Seized with it from a ship in Vancouver harbor was $4 million in cash, sent along to get the shipment distributed here.

"This was all fuelled by people paying $35 or $40 on the street in Canada for a shot of heroin or cocaine or whatever," Chief Supt Stamler said.

Financiers, lawyers, accountants, transportation specialists, and other experts are used to move profits through international banking systems so skillfully that it is extremely difficult to connect the money with drugs. From Canada, money is laundered through Grand Cayman, the Bahamas, or sometimes Switzerland.

He believes Bill C-61 will help by allowing seizure of assets. However, enforcement has been made more difficult and time consuming by stringent controls over wire tapping and search warrants.

"I would say police work costs twice as much as it did in 1979. To get a search warrant, we may take five hours; in 1979, it took one hour. . . . We are now doing half the street work we were doing before."

Chief Supt Stamler told a questioner legalizing drugs would indeed eliminate the huge profits but would not eliminate the social problems. Drugs would be cheaper and therefore more widely used, with attendant increases in problems such as impaired driving, and without means of measuring impairment due to cocaine and heroin use, or a mixture of drugs, such as MDA and heroin or alcohol.

The main reason, he said, is if Canada took such action in isolation from the rest of the world, United States heroin addicts would be up "buying at the corner store, as has happened in Holland."

NEWS

House of Commons health committee says:

Canada needs national drug institute

By Elda Hauschildt

TORONTO — Canada needs a "national centre on substance abuse," says an all-party House of Commons committee after studying alcohol and other drug issues for a year.

Creation of a national centre is one of the major recommendations among 39 made by the Standing Committee on National Health and Welfare in its recent report, *Booze, Pills & Dope: Reducing Substance Abuse in Canada*.

The federal government has approximately five months — 150 Commons working days — to respond to the report, says committee chairman Bruce Halliday, MD.

Because alcohol and other drug issues, and the Commons committee's recommendations, involve several federal ministries — health and welfare, solicitor-general, justice, revenue, external affairs — "if there is to be any substantive response from the government, it will have to have Cabinet approval," Dr Halliday told **The Journal**.

The proposed national centre, the committee says in its report, should have a governing body of representatives from federal and provincial governments, the private sector, labor, and voluntary organizations.

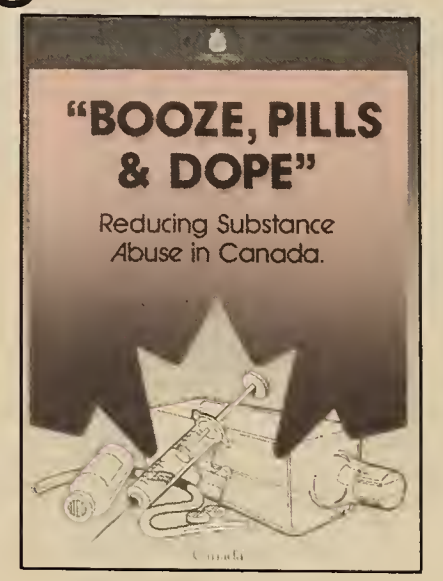
"The experience, special skills, and the expertise of Canadians should be regarded as a national resource. There is a pressing need to disseminate the best information possible and to develop a permanent forum for addressing substance abuse issues.

"Our efforts in this area should be formed into a cohesive whole to be seen and used nationally."

Before preparing its report, the committee spent months hearing witnesses from all areas of the addictions field: leaders of provincial addiction agencies; experts in prevention, research, and treatment; representatives of community groups; employee assistance program providers; and, both workers and former clients of treatment centres (**The Journal**, July).

Government (Progressive Conservative) representatives on the committee include Dr Halliday; Barry Turner, vice-chairman; Moe Mantha; Paul McCrossan; and, Barry White. Sheila Copps is the Liberal party member, and Howard McCurdy represents the New Democratic Party.

The committee proposes the national centre "develop a national, substance abuse data base," and "establish a clearinghouse for the dissemination of national and international information on alcohol and other substance abuse."



Further, it suggests the centre should: conduct and promote basic and applied research, disseminate information, engage in public education and prevention, and encourage the application of new knowledge in clinical and prevention programs, and research.

"Duplication of effort must be avoided," says the report. Existing Canadian resources for training, research, program evaluation, prevention, and public information should be brought together.

"A process should be developed in which the various centres of distinction can serve all Canadians."

Under the national drug strategy announced last May, Health Minister Jake Epp appointed H. David Archibald a one-man task force to identify drug demand-reduction programs in Canada that could serve the government's national strategy (**The Journal**, October).

Dr Halliday points out that some of the Commons committee's recommendations have been initiated within the national strategy, development of which overlapped with the committee's study.

The committee's other recommendations include:

- a new 50/50 cost-sharing program with the provinces, with increased funding for prevention programs, and development of a similar program for treatment and rehabilitation services;
- identification of children as first priority for treatment funding;
- provincial consideration of a probationary licence system for new drivers, making it an offence to drive with any measurable alcohol in the body;
- maintenance of a level of federal taxation to ensure that prices of beverage alcohol do not decline relative to real personal income;
- provision by beverage alcohol advertisers of public education messages equal to 15% of the total dollar value of their advertising;
- legislation requiring Canadian financial institutions to facilitate the tracing of proceeds of crime;
- legislation to close head shops; and,
- warning labels on all alcoholic beverages.

Economic recession could lead to EAP cuts

By Terri Etherington

OTTAWA — Employee assistance programs (EAPs) could be a casualty of the economic recession expected to follow October's stock market crash.

Speakers at Input 87, the 7th Biennial Symposium on EAPs, touched on the issue of the future of EAPs in the event of an economic downturn.

While some expressed strong concern that management could see worker-help programs as fat to be trimmed from budgets, others saw a time of opportunity to retrench, to deal with basic employee problems such as alcohol and other drug abuse, or to gain strength by broadening the support base to all corporate levels.

Planning, anticipation, and strong marketing could prevent an EAP from hitting the chopping block in a recession, keynote speaker Linda Tarrant told **The Journal**.

"If the EAP people have marketed it well, and that means they have senior people in the company who helped create the program, then it's my guess they'll still be there."

Ms Tarrant, a psychologist with the Percy Group, a Vancouver-based consulting firm, said experience with organizations for the handicapped in the United States taught her a valuable lesson. "We never anticipated that programs would be stopped or cut, because we thought they were right. We believed in them and sold them, and so we figured they'd keep going. Well, they're cut now.

"If we'd planned better, if we'd anticipated better, if we'd marketed ourselves better . . . but we didn't feel we needed to."

EAP practitioners, she said, should not just create programs and ask others to buy into them, but should open the process up, let people from senior levels — boards of directors as well as senior management — help plan programs.

Jim Stimson, EAP coordinator for Macmillan Bloedel Limited, Vancouver, believes union participation, particularly financial participation, is the key to longevity even in a recession.

Mr Stimson told a workshop his company has gone through "every kind of disaster you can think of from downsizing, to mergers, to union raids," over the years. Twice in the past, the company eliminated the EAP: "Why? Because it paid for it — it had full authority."

Now, the unions participate in funding and the EAP is a joint union/management venture.

"We lost a million or a billion bucks the other day in the stock market issue. But, even when the unions participate only 10% financially, the likelihood of management ever trying to uproot that — they may shake a little dirt off — they will never uproot it. There is a tremendous impact when they see unions in a non-negotiating, non-bargaining-table situation put up 10% or 15% of the cost of that service. There's longevity in that."

Quebec employee programs report increase in cocaine problems

By Terri Etherington

OTTAWA — Quebec has been hit first and hardest with cocaine problems in the workplace suggests a "quick, unscientific" survey of employee assistance program (EAP) practitioners across Canada.

The survey, by Don Baran for Input 87, the 7th Biennial Symposium of Employee Assistance Programs, polled selected EAP providers in all provinces.

Quebec EAPs report an increase of between 40% and 70% in cocaine abuse in their caseloads since January, 1985; the cases are spread throughout corporate levels but most evident in the middle- to upper-income groups.

They also report a substantial increase in staff-time costs to treat cocaine users and provide intensive, sustained follow-up.

Manitoba EAPs report a 50% increase in cocaine use among clients, with 80% of those in the salaried group.

In British Columbia, a 3% to 5% increase has been seen, primarily in hourly-rated workers and among those 20 to 30 years old. In Alberta, the 5% to 6% increase since 1985 has been fairly evenly split between the hourly and salaried groups.

Mr Baran told an Input workshop that Saskatchewan reports no increase since 1985, with incidents limited to the "odd case." And, Atlantic Canada is "lotus land east . . . with little if any evidence of cocaine in the employed population."

Statistics for Ontario came from the Addiction Research Foundation's study of adult drug use from 1984 to 1987, which shows an increase of 2.5% in cocaine use by males and 1.5% by females.

Mr Baran, a member of the Input planning committee, is president of Baran, Inc, an international EAP consulting firm, and a director of two Montreal addiction treatment centres, Maison Jean Lapointe and Phoenix Centre.

EAPs that are seeing more cocaine-clients are beginning also to see increased costs, Mr Baran said. "The potential for draining both staff time and company treatment budgets is significant."

Also, he said, EAP staff need more training in identifying and dealing with cocaine users.

Statistics from the Royal Canadian Mounted Police (RCMP) confirm cocaine use is on the rise across Canada, said Constable Shelley Baker, RCMP, drug section, Ottawa. Cocaine-related offences have increased to 6,500 in 1986 from 2,100 in 1981, or 11.6% of all drug charges in 1986 compared to 4.3% of offences in 1981.

Mr Baran urged EAPs to begin tracking cocaine use among clients, which is not generally being done now, and to return to Input 89 with hard figures and a clearer picture of the impact on EAP costs.

Britain set to extend pub-opening hours

Serving more suds: fight moves to Commons

By Alan Massam

LONDON — Despite angry opposition from the medical establishment, England and Wales have moved a step nearer to all-day pub opening with a massive parliamentary vote in favor of a new law to liberalize licensing hours.

By a majority of 297 votes to 87, the House of Commons favored the second reading of a bill which will allow licensed premises to remain open all afternoon except on Sundays. All-day opening already exists in Scotland.

The fight to oppose the extended hours now moves into the working committees of the House, where details of the new bill will be worked out. However, opponents fear they will not be able to make significant changes before it becomes law at third reading by next spring.

Prime Minister Margaret Thatcher and Home Secretary Douglas Hurd are known to be in favor of all-day pub opening, presumably because the government has won many votes by increasing what it describes as the freedom of the individual.

It is believed, however, that Mr Hurd is prepared to accept random breath testing to curb the worst consequences of increased drinking — carnage on the roads.

The new bill proposes 12-hour opening from 11 am to 11 pm and contains a number of other important provisions.

Opposition is particularly concentrated on concern about alcohol consumption by young people. A spokesman for Action on Alcohol Abuse said a recent national survey had shown that 50% of boys and 30% of girls aged 11 years drink alcohol at least once a week.

It also revealed that 32% of 15-year-old boys and 26% of girls of that age report regular drinking in public houses. By age 17, this has increased to 91% of boys and 35% of girls.

The spokesman added 80% of British teens report they have experienced adverse consequences of alcohol consumption, and drink is implicated in 45% of all fatal road accidents involving young people.

In the last 30 years, drunkenness convictions for those under 18 years in Britain have increased by 740%.

Derek Rutherford, director of the Institute of Alcohol Studies, told **The Journal** that he found the vote in favor of all-day opening "astonishing."

He says the measure would certainly increase consumption, yet the immense harm caused by alcohol abuse is now widely accepted.

"It seems the government is influenced by the fact that alcohol damage is greater elsewhere in Europe so it feels we can afford to drink more," he said.

NEWS

RESEARCH UPDATE

Smoking linked to hearing loss

Workers employed in noisy environments are more likely to suffer hearing loss if they are smokers. This relationship was found in a study of 2,348 white males between the ages of 18 and 59 years, employed by an aerospace company and participating in a hearing conservation program. All of the participants worked in an area where the average noise level was 85 decibels. When the employees joined the company, researchers from the division of occupational health at the University of Southern California School of Medicine and the Northrop Corporation gave them a medical questionnaire and a pure-tone audiometry test, which was repeated annually. To compare risk factors, 845 of the subjects with the worst hearing losses were compared with 817 subjects in the same age categories with the lowest degree of hearing loss. Statistical analysis showed smoking was one independent factor responsible for hearing loss. Subjects were at more risk as the reported number of pack-years of smoking and current packs-per-day consumption increased. The researchers speculate smoking could contribute to hearing loss by adversely affecting the microcirculation of blood in the ear and significantly worsening an already compromised metabolism.
Journal of Occupational Medicine, September, 1987, v.29:741-745.

Drug use: part of a teen behavior syndrome

For many purposes, adolescent use of various drugs can be considered a single type of behavior regardless of the specific drug being used, Californian researchers suggest. They had 1,447 Grade 10 students in four North California high schools complete a survey and undergo basic physical assessment in September, 1985. The researchers, from the Center for Research in Disease Prevention, Stanford University School of Medicine, say their findings also suggest alcohol and other drug use may exist as part of a syndrome of adolescent problem behaviors. The study population, who averaged 15 years of age, reported that alcohol was the most commonly used drug by both sexes, followed by tobacco and marijuana. Multiple regression statistical analysis showed an increased level of use in both boys and girls is most strongly predicted by whether they think their friends use marijuana or not. Other variables include school performance, perceived safety of cigarette smoking, and use of diet pills, laxatives, or diuretics for weight control. The results, the researchers say, indicate "adolescents at risk for involvement with substance use might also be at risk for participating in other problem behaviors." The finding that increased alcohol and other drug use is linked with the use of drugs for weight control could represent a significant new risk factor in identifying these adolescents, the study concludes.
Journal of the American Medical Association, October 16, 1987, v.258:2072-2076.

Crack users report psychoses, violence

Crack users are more likely to report psychotic or violent feelings than users of other forms of cocaine. Three New York physicians reviewed 80 consecutive cases of cocaine use presenting to an emergency room over seven months in 1985/86. The physicians, from the College of Physicians and Surgeons at Columbia University, separated the patients into four groups depending on their most recent form of cocaine use. They then conducted mental status examinations as well as recording psychotic symptoms, finding crack users reported significantly more psychotic symptoms and thoughts or acts of violence. Crack users also had an increased rate of admission to the emergency ward in contrast to freebasing patients or those using the drug intravenously or intranasally. The researchers conclude that in the emergency room, crack-using patients should receive careful evaluation and comprehensive treatment.
The Lancet, August 22, 2987, No:8556:451.

Alcohol death rate underestimated

Death certificates grossly underestimate the involvement of alcohol in mortality, an evaluation of more than 400 such certificates in the United States concludes. The study at the Center of Environmental Health, Centers for Disease Control, Atlanta, was part of a large-scale study to assess post-service morbidity and mortality of US soldiers who entered the service between 1965 and 1971. Death certificates and other available medical and legal records were obtained for 425 of 446 post-service deaths that occurred up to the end of 1983, among more than 18,000 subjects. Each death certificate was coded according to the reason for death; a medical panel then assigned underlying and contributory causes of death based on review of the medical and legal records. While 21 deaths were seen as being alcohol-related on the basis of information on the death certificates, the two physicians on the panel said 133 (more than six times as many) were alcohol-related. For example, with the most frequent cause of death in the subjects — motor vehicle injuries — the medical panel, defining "excessive blood-alcohol levels" as greater than 0.10%, found the drug to be involved in seven times as many cases as the original certifiers. The researchers say the discrepancy in reporting is largely attributable to the omission of data on blood-alcohol levels from death certificates in deaths due to injury. To enhance the accuracy of such vital statistics, the study concludes, all available ante-mortem and post-mortem information should be considered before death certificates are finalized.
The Journal of the American Medical Association, July 17, 1987, v 258:345-348.

Pat Rich

Ear/nose symptoms plague pregnant smokers

By Paul Szabo

CHICAGO — Pregnant women who smoke can make their pregnancies miserable for themselves as well as endanger the health of their unborn.

Pregnant smokers are more at risk of developing stuffy noses and blocked ears often associated with pregnancy, says a report presented here at the annual meeting of the American Academy of Otolaryngology — Head and Neck Surgery.

Craig Derkay, MD, a resident in the department of otolaryngology, University of Pittsburgh School of Medicine, said new, non-invasive methods of measuring the function of the eustachian tube allow researchers to prove that "rhinitis of pregnancy" really does exist as a clinical entity.

While clinicians have long known that pregnant women often complain of ear and nasal symptoms associated with disrupted eustachian tube function, the study was the first to show eustachian tube dysfunction associated with pregnancy.

Dr Derkay compared a group of 20 symptomatic, pregnant women with a matched group of pregnant women who were asymptomatic and with a non-pregnant control group. A significantly higher proportion of symptomatic women were shown to be dysfunctional.

The only risk factors found to be associated with the condition were a past history of otologic symptoms and current cigarette smoking.

He said eight of 11 women who smoked during pregnancy had symptoms associated with eustachian tube dysfunction.

As for the condition of "rhinitis of pregnancy" itself, Dr Derkay said the most probable cause is circulating hormones. The condition almost always disappears following birth of the child.

Pregnancy: circulating hormones

Detox workers are censured

Patient's death prompts action

VANCOUVER — A coroner's jury here has recommended greater attention be paid to the physical status of intoxicated people admitted to detoxification centres.

Three workers at a local detox centre were disciplined for failing to administer cardio-pulmonary resuscitation (CPR) to a 49-year-old man who had stopped breathing. Police found the man conscious, but in an extreme state of intoxication on a downtown street; he died of alcohol poisoning four hours after admission.

At an inquest, detox workers stated they had difficulty assessing the extent of the man's intoxication because the centre had no blood-alcohol-level (BAL) testing apparatus.

The employee who found the man dead admitted she went for help rather than attempt to administer CPR. "The first thing I needed was assistance, and the concurrent thought was that he had been dead for some time," she said.

The employee said she was disciplined by superiors for not immediately initiating CPR. As well, a centre nurse and acting supervisor testified they were censured for the subsequent group decision not to use CPR.

A former centre worker said previous requests for equipment had been denied, and visual checks of the man had been made every 15 minutes. The last person to see the man alive said there had been no indication his condition was worsening: "I used a pain stimulus, and he moved his hand and foot. He was breathing: he grunted but didn't speak."

The inquest decided the man's death was accidental and made several recommendations:

- lights should be left on in patients' rooms at all times,
- patients' vital signs should be taken on admission,
- a policy review should be implemented to teach staff when special attention is required, noting the level of care on the patient's chart,
- key-operated alarms in each room for staff emergency use should be considered, and
- patient room checks by staff should include physical assessment of clients' conditions.

NIAAA undertaking evaluation

Alcohol field must show efficacy

By Harvey McConnell

ST LOUIS — Evaluating and documenting the efficacy of alcoholism treatment is the only way to protect the chemical dependency field from its current legion of doubters.

This is why the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) is undertaking an evaluation, said Enoch Gordis, MD, NIAAA director. "We want to be sure in the claims we make."

Dr Gordis: "Alcohol treatment is something all of us have given a large piece of our life (to), and yet we know very well in the community at large and some places in Congress, there is a kind of distrust of alcohol, and I think substance abuse, treatment."

He told the annual conference here of the Alcohol and Drug Problems Association of North America, the way to disarm doubters is to produce evidence of efficacy, as the heart disease and cancer fields have done.

"It is important for the security of our field to document the efficacy of our claims and tell which population derives the best benefit from the settings and modalities we have — the two things are not the same," he continued.

"Even if it means eventually surrendering some of our claims, if we are secure about the rest of them, I think our future is secure. So, treatment evaluation is important, and the future and security of our field ultimately will have to be based on documenting what our assertions are."

Impaired physicians resisting help

By Paul Szabo

ST ANDREWS — Apathy plagues any attempt to deal with the problem of impaired physicians in New Brunswick, says the head of the physicians-at-risk committee of the provincial medical society.

Ihsan Kapkin, MD, a Saint John psychiatrist, said the province has potentially 100 impaired physicians, but only eight came forward for treatment last year.

Dr Kapkin told the annual meeting of the New Brunswick Medical Society that a telephone hotline established 20 months ago has not been used once, and fewer than 18 of 200 invited doctors attended a lecture on professional addiction given by an international expert.

He said the physicians-at-risk committee, established four years ago, has identified 23 impaired physicians — most of whom abuse alcohol.

While this is a fairly successful number to identify, he said, it represents the "tip of the iceberg."

Dr Kapkin: "Our committee is seriously concerned with the apparent silence and near impossibility to reach out to our impaired colleagues. The moral responsibility for this appalling apathy and the lack of involvement of our sick colleagues should be on the conscience of every physician in this province."

Fear of financial ruin is one reason doctors are afraid to report the problem, so Dr Kapkin proposed the medical society establish a fund to provide interest-free loans to physicians undergoing treatment and rehabilitation. The idea was accepted by the meeting.

NEWS AND COMMENT

Spuds Mackenzie no 'party animal'

Youth-targeted beer ads draw fire

ST LOUIS — A stuffed dog with an advertisement on its bottom and a television commercial which directly links relief of stress with a bottle of beer are under attack by leaders of the United States chemical dependency field.

Resolutions have been passed by the Alcohol and Drug Problems Association of North America (ADPA) and the US National Association of State Alcohol and Drug Abuse Directors in protest, calling for Congressional action against the Anheuser-Busch and Genesee Brewing companies.

Anheuser-Busch has licensed its popular "Spuds Mackenzie" stuffed dog which is now being sold in toy stores with a "Bud Light" tag on its bottom. Posters and T-shirts aimed at the college market label the dog "a party animal."

Genesee has produced two humorous commercials — one of a Gary Hart-like politician under fire from reporters and another of a camper who is verbally assaulted by his wife, unseen in a tent, for bringing her along — with the tag-line both men could use a "Genny" now.

The resolution adopted during the ADPA annual conference here pointed out that the dog is marketed to an audience below the legal drinking age, and the Genesee commercials violate restrictions on using alcohol as an answer to stress.

"Childhood product-identification with substances that have seductive and addicting properties and the connection of alcohol to alter one's mood clearly do not have any part in the marketing of alcohol," ADPA executive director Karst Besteman told **The Journal**.

The camping commercial is especially offensive because the man jumps into his motorboat and speeds away to buy beer. "One of the big problems we have with pleasure-boat operators, as the Coast Guard will tell you, is the inappropriate use of alcohol," Mr Besteman added.

Older alcoholics are 'well hidden'

TORONTO — A segment of the older population shows signs of memory loss, unsteady gait, and bad nutrition, even if they don't use alcohol. At the same time, the older have lots of leisure time for drinking: traditional treatment programs are not designed for them when they run into problems; and, often, they do not seek help.

There are no easy solutions to these problems: "These people are very well hidden," says Sarah Saunders, MD, of the Hospital Outreach Service at Ontario's Addiction Research Foundation (ARF) here. "It's very difficult to diagnose them."

Dr Saunders says treating older alcohol or other drug users necessitates an approach that considers a variety of lifestyle problems often accompanying old age.

In many cases, older people have other ailments, and very little alcohol produces the same effect as heavier drinking by someone younger. Many older people were also raised to believe drinking is not acceptable and feel guilty they are using it.

"The average age for an alcoholic in treatment programs is 35, not 75, and programs are geared to those 35," Dr Saunders said here at a public forum, Mixed Reactions: Seniors, Alcohol, and Drugs, sponsored by the ARF and the Mayor's Committee on Aging.

"Consequently, the elderly have been perceived to be few in number and almost untreatable."

Margaret Flower, executive director of the Community Older Persons Alcohol Program (COPA), said adult children of older drinkers feel guilty if they don't buy their parents alcohol and cut off from family events because of the stigma of having a parent or relative with an abuse problem.

Amy Thomson of the Mayor's Committee on Aging says the medical profession tries too often to solve health problems by prescribing drugs. Many older people use several prescription and over-the-counter drugs daily; mixing them with alcohol can result in serious health consequences.

Saskatchewan updates liquor laws

By Deana Driver

REGINA — The new Alcohol Control Act proposed by the Saskatchewan government would place larger penalties on infractions such as alcohol consumption in a vehicle, bootlegging, or providing alcohol to minors.

The act, expected to become law in the spring, would replace the Liquor Act of 1925 and the Liquor Licensing Act of 1959.

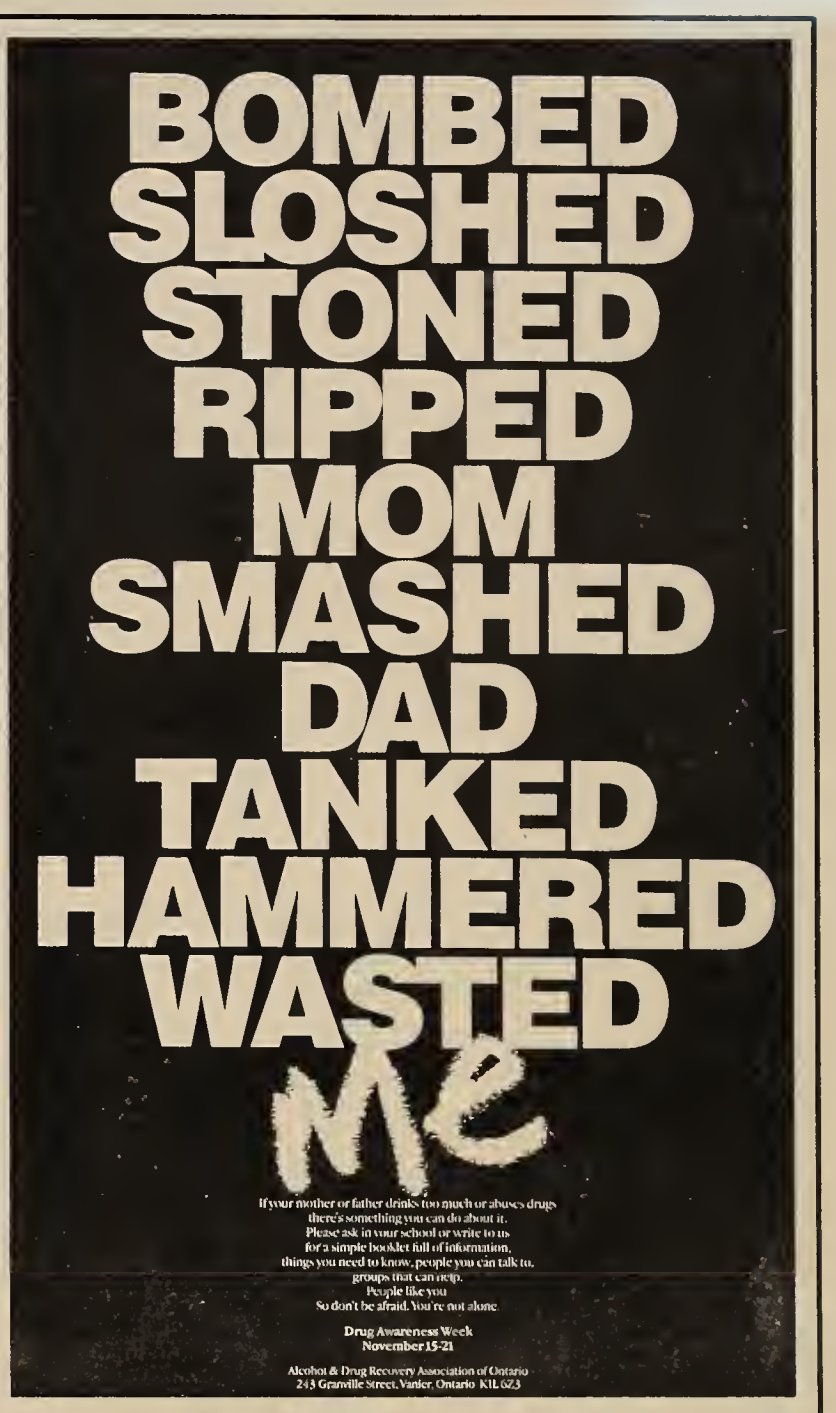
It offers greater opportunities for the tourism and hospitality industries, while addressing alcohol abuse, said Graham Taylor, the provincial minister responsible for the Saskatchewan Liquor Board.

Local governments would have more say in the days and hours of operation of licensed establishments, and special occasion permits.

Food service would be required in all establishments that serve alcohol, and brew-pubs and bed-and-breakfast outlets may be licensed in some communities.

The definition of alcoholic beverages would change to include drinks containing more than 0.5% alcohol by volume rather than the present 1.13% alcohol by weight, and penalties for abuse would increase.

Fines for serving minors, for example, would range from $200 to $2,500, with a possible two months in jail. The present fine is $50 to $100.



Tell Someone

This poster and a four-minute music video that "speaks to teenagers in a language they can understand" are centrepieces of a new campaign launched during Drug Awareness Week in November by the Alcohol and Drug Recovery Association of Ontario, a non-profit, province-wide organization of more than 80 treatment facilities, recovery homes, and detoxification units. The campaign, whose theme is* **Tell Someone**, *is aimed at teenagers — from 12 through 17 years — with parents with alcohol or other drug problems; it conveys the message: "If your parent's drinking is interfering with your life, talk to someone about it. You're not alone; there are people who care . . . ." As well as practical information for teens, it includes a 24-page booklet and other resources for schools and social agencies. Association officials believe the campaign is the first of its kind in Canada. (*PO Box 971, Stn B, Willowdale, Ontario, M2K 2T6.)*

INSIDE OUT

A disease or not a disease

Well, well. I'm going on trial.

This month, *The New York Times* reports, the United States Supreme Court will be faced with an interesting and profound philosophical conundrum: is alcoholism, as a majority of the medical establishment and hordes of laymen now believe, really a disease, with more and more evidence coming in daily that it's genetically based?

Or is it, rather, a behavioral problem in which one of the major components is the moral factor?

The justices have agreed to debate this issue following a challenge against the US Veterans Administration, which still excludes alcoholism from the disabilities and illnesses that permit veterans more time to claim education benefits. The huge veteran's bureaucracy considers alcoholism a matter of "wilful misconduct" — a view that flies in the face of the accepted theories.

I am happy I'm not one of the arbiters in this case.

It's not merely that an anti-disease theory ruling would have potentially heavy consequences in the addiction treatment field, particularly, as the *Times* reports, in the area of employee assistance programs (if alcoholism is not a disease, then let's just dismiss the affected worker and write him off as a bad loss because we don't need all this grief).

And, it's not merely that society might very well decrease substantially its output of compassion toward alcoholics.

No, there's another side too. There's

There's also the impact the decision would have on how alcoholics feel about themselves

also the impact it would have on the way alcoholics view themselves. I wonder, for instance, about the consequences if the US Supreme Court justices come down foursquare for the disease theory, and then everybody pats himself on the back for being so enlightened.

Because, you see, the disease theory can also be carried to extremes: in another case now before courts in the US, a man is suing his company to collect disability payments because his alcoholism makes it impossible for him to work. Now, I don't know about you, but I think this is an example of liberalism run amok, a contemporary version of "the Devil made me do it."

So no, no, the justices' decision, if they are wise human beings, will not be a simple fiat: this is a disease *or* this is a moral failure of huge proportions. It should, properly, come down heavily in the middle of the road, a centrist view of the issue that would be, indeed, quite revolutionary.

Because if I know anything at all about this question — and it's one I've thought about many times, starting when, as a boy, I would cast a cold, stern, biblically condemnatory eye on my alcoholic father, and continuing up to the bitter day I had to accept my own "disease" — it is this: alcoholism — any drug addiction — is the only physical disease that affects the victim's moral superstructure, and sometimes it seems to be the only physical disease caused by one's moral, or amoral, superstructure.

It was, it still is, an overwhelming mystery to me — me who had accepted the disease theory for years — to have experienced the tremendous spiritual implications of suddenly stopping drinking.

Why, I often wondered in the rehabilitation clinic, did I seem to be undergoing such wild swings in mood, from an enveloping ecstasy triggered finally by seeing some cause to rejoice, to the endless, cavernous deeps of rock-bottom remorse, guilt, and hopelessness?

Did all of that come from happening to be the son of an alcoholic? Did I never have a choice in the matter? Could I have stopped drinking in my 20s? Could I have changed my "wilful misconduct?" Or, was it inevitable that 11 days after my 40th birthday I would wake up in a cold hospital corridor knowing my life had changed forever?

Even if one knows he's genetically predisposed to becoming an addict, will that help him stay away from his drug of no-choice down the road? Does someone have a choice — for a while — of stopping and then, at some mysterious crossroad, is that choice taken away, physically and morally?

The simple truth, of course, is that I don't know the answers to these questions.

And I'm certain the august US justices don't know either.

Nonetheless, I wish them luck: Solomon would have scratched his head on this one.

This column, exploring addictions from the "inside out," is by a freelance, Canadian journalist.

LETTERS

Survey of mid-US students

Rural crack use reported

The media have presented documentaries indicating there are serious epidemics of crack use in a few larger United States cities. In these places, there is apparently heavy crack use among older drug users and by children.

How fast is crack spreading to more isolated areas?

From February to May, 1987, 24 schools in rural areas or small towns in the mid-US administered the American Drug and Alcohol Survey (TM) to Grade 8 and Grade 12 students. The schools participated as part of a small business project that provides schools with data on their own local rates of drug use, a project I headed with Colorado State University.

The results suggest crack is rapidly becoming available everywhere. With one exception, crack use was reported by students in every community. The exception was a rural location where the entire school district included only 96 senior students. In every other community, at least a few seniors had tried crack (from 2% to 5%).

Use in Grade 8 was rare, although a few had tried crack in some locations.

The results are likely to be accurate, since the survey includes internal checks for consistency and for exaggeration and those surveys were removed before analysis.

The following table shows what percentage of students using other drugs have tried crack.

Drug used	*% trying crack*
Multi-drug users	18.2
Stimulant users	13.6
Heavy marijuana users	0.0
Heavy alcohol users	1.4
Occasional drug users	9.9
Light marijuana users	3.8
Drug experimenters	1.1
Light alcohol users	0.6
Negligible or no use	0.7

Many of those trying crack are already heavily drug-involved multi-drug users or stimulant users who are involved in a drug lifestyle. They use drugs regularly and take a drug other than marijuana at least once a month.

But, crack is also being tried by youths who only take drugs occasionally (less than once a month), or who use marijuana only once or twice a month (generally at parties).

Crack is already available pretty much everywhere in the US, even in rural areas. Its use is likely to spread rapidly, both in the US and Canada.

Despite all the negative publicity, there seem to be few barriers to trying crack. It is being tried not only by those who are already heavily into in a drug lifestyle, but also by young people who only use drugs occasionally.

Ruth W. Edwards
Executive director
American Drug and
Alcohol Survey
Collins, Colorado

Golobitsh

Rural teens: few barriers to trying crack despite negative publicity

Balance needed on COAs

Referring to Richard Gilbert's fine article, Children of Alcoholics: III (November), AA (Alcoholics Anonymous) has survived and grown for more than 50 years because it is a program of attraction, not promotion, and because its goals and structure are clearly defined and limited to alcoholics.

Unfortunately, some people in the COA (children of alcoholics) movement seem to feature promotion rather than attraction. Also, the COA field has so many "stars" that, in my opinion, any focus is becoming dangerously blurred.

If the COA movement becomes too diffuse, its well-meaning efforts to help COAs may founder just as the Oxford Movement did.

Please continue to publish both sides of the COA picture.

Lucy Barry Robe
Cold Spring Harbor
Long Island, New York

The Journal

A monthly publication for professionals on developments, issues and events of national and international significance in the field of alcohol and other drugs

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Conferences

Treatment of Addictive Disorders 14th Annual Advanced International Winter Symposium — Jan 31-Feb 5, Colorado Springs, Colorado. Information: Gary G. Forrest, Psychotherapy Associates, 3208 North Academy Blvd, Ste 160, Colorado Springs, CO 80917.

February

Canadian Society of Hospital Pharmacists Professional Practice Conference — Feb 1-5, Toronto, Ontario. Information: Barbara Cole, 123 Edward St, Ste 603, Toronto, ON M5G 1E2.

Connections 88, International Symposium of Research and Public Policy on Aging and Health — Feb 8-10, Saskatoon, Saskachewan. Information: Saskatchewan Health Research Board, Ste 5, 3002 Louise St, Saskatoon, SK S7J 3L8.

Ontario Psychological Association 41st Annual Convention — Feb 11-13, Toronto, Ontario. Information: Yonet Schroder, executive assistant, 730 Yonge St, Ste 221, Toronto, ON M4Y 2B7.

4th Annual Children of Alcoholics Convention — Feb 14-17, San Francisco, California. Information: US Journal Training Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

8th Annual Betty Ford Center Conference on Alcoholism/Chemical Dependency: Integrating Concerns in Chemical Dependency — Feb 15-17, Rancho Mirage, California. Information: Jackie Lycett, Annenberg Center for Health Sciences, 39000 Bob Hope Dr, Rancho Mirage, CA 92270-3298.

12th Annual Conference on Alcoholism and Drug Abuse — Feb 17-19, El Paso, Texas. Information: Vicki Hollander, office of continuing medical education, Texas Tech University Health Sciences Center, 3601 4th St, Lubbock, TX 79430.

American Medical Society on Alcoholism and Other Drug Dependencies 2nd National Forum on AIDS and Chemical Dependencies — Feb 18-20, Phoenix, Arizona. Information: Barbara Turner, MTS, 1724 Barkston Ct, NE, Atlanta, Georgia 30341.

11th World Conference of Therapeutic Communities — Feb 21-26, Bangkok, Thailand. Information: Justice Amnuay Intuputi, chairman, organizing committee, Non-Government Organization, Anti-Narcotics Coordinating Center, National Council on Social Welfare, Thailand, 257 Rajvithi Rd, Bangkok, 10400, Thailand.

Native Conference on Addictions: Bridges into Tomorrow — Feb 22-25, Vancouver, BC. Information: Native Association of Treatment Directors, Box 1882, Saskatoon, Saskatchewan, S7K 3S2.

4th Annual National Convention on Children of Alcoholics — Feb 28-March 3, New Orleans, Louisiana. Information: Holly Lenz, National Association for Children of Alcoholics, 31706 Coast Hwy, #201, South Laguna, California 92677.

White House Conference for a Drug-Free America — Feb 29-March 3, Washington, DC. Information: William Oltmann, conference executive deputy director, #726 Jackson Place NW, Washington, DC 20503.

March

American College of Physicians 69th Annual Session — March 3-6, New York, NY. Information: Registration services, American College of Physicians, 4200 Pine St, Philadelphia, Pennsylvania 19104.

1st International Conference on the Global Impact of AIDS — March 8-10, London, England. Information: Conf ZZ, Emap Maclaren Exhibitions Ltd, Box 138, Token House, 79-81 High St, Croyden CR9 3SS, England.

New York State Substance Abuse Legislative Conference — March 9-10, Albany, New York. Information: LaZette McCants, Narcotic and Drug Research, Inc, 1501 Broadway, Ste 1914, New York, NY, 10036.

Alcohol and Other Drug Information Resources International Symposium — March 10-12, San Diego, California. Information: Tom Colthurst, University of California, San Diego X-001, La Jolla, CA 92093.

American Orthopsychiatric Association (ORTHO), Adapting to Social Change: Therapy, Technology, and Services — March 27-31, San Francisco, California. Information: ORTHO, 19 W 44th St, Ste 1616, New York, NY 10036.

April

New York State Methadone Conference — April 14-15, Catskills, New York. Information: Connie Taylor, Narcotic and Drug Research, Inc, 251 New Karner Road, Albany, NY 12205.

National Parents' Resource Institute for Drug Education (PRIDE) 11th Annual International Conference on Youth and Drugs — April 14-16, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave NE, Ste 1002, Atlanta, GA 30303.

National Council on Alcoholism, National Alcoholism Forum, — April 21-24, Arlington (Crystal City), Virginia. *Alcohol and Other Drugs: Recent Knowledge/State of the Art: Marty Mann Course for Counsellors; Ruth Fox Course for Physicians.* Information: Allen Haveson, NCA, 12 W 21st St, 7th fl, New York, NY 10010.

19th Annual American Medical Society on Alcoholism and Other Drug Dependencies Medical-Scientific Conference — April 21-24, Arlington (Crystal City), Virginia. Information: Louisa Macpherson, conference manager, 21 Half Mile Common, Westport, Connecticut 06880.

Beyond the Road Less Travelled: Spirituality and Personal Growth — April 30, Toronto, Ontario; July 16, Vancouver, British Columbia. Information: Marge Queenan, conference director, Lifecycle Learning Resources, 53 Langely Rd, Ste 360, Newton, Massachusetts 02159.

May

Northeastern Conference on Alcoholism and Drug Dependence (NECAD 88) — May 1-4, Newport, Rhode Island. Information: Jane Drury, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

3rd Annual Conference of the National Association of Student Assistance Programs and Professionals — May 1-4, Chicago, Illinois. Information: NASAPP, Box 3148, Oakton, Virginia 22124.

Anglo-American Congress on Alcoholism and Drug Abuse II — May 6-15, Brighton, England. Information: Centers for International Development, 14650 Detroit Ave LL30, Cleveland, Ohio 44107.

American Psychiatric Association Annual Meeting — May 7-12, Montreal, Quebec. Information: Kathleen Bryan, 1400 K St NW, Washington, DC 20005.

The Journey is My Home: 2nd National Conference for Children of Alcoholics, Canadian Association of Children of Alcoholics — May 11-13, Toronto, Ontario. *ACOA treatment workshops for professionals; member workshops for personal growth.* Information: Conference coordinator, Box 159, Stn H, Toronto, ON M4C 5H9.

Forum on Alcohol and Drug Abuse: Issues in the Black Population—May 11-13, Columbia, South Carolina. Information: Elaine Dowdy, South Carolina Commission on Alcohol and Drug Abuse, 3700 Forest Dr, Columbia, SC.

Healing the Loss of Childhood— May 14, Toronto, Ontario; June 11, Vancouver, British Columbia. Information: Marge Queenan, conference director, Lifecycle Learning Resources, 53 Langely Rd, Ste 360, Newton, Massachusetts 02159.

PRIDE CANADA 4th National Conference on Youth and Drugs — May 26-28, Ottawa, Ontario. *For youth, parents, and professionals. Plenary and workshop sessions by national and international scientists, health professionals, and policy makers.* Information: Glenda Klombies, conference coordinator, PRIDE Canada Inc, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

June

Canadian Lung Association Annual Conference — June 2-5, St John's, Newfoundland. Information: Les McDonald, 75 Albert St, Ste 908, Ottawa, Ontario KIP 5E7.

Substance Abuse 88: 10th Annual New York Substance Abuse Conference — June 6-9, Rochester, New York. Information: LaZette McCants, Narcotic and Drug Research, Inc, 1501 Broadway, Ste 1914, New York, NY 10036.

Ontario Medical Association 108th Annual Meeting — June 6-10, Toronto, Ontario. Information: Erma Walker or Heather Smith, Ste 600, 250 Bloor St E, Toronto, ON M4W 3P8.

4th International Conference on AIDS — June 12-16, Stockholm, Sweden. Information: Conference on AIDS, c/o Stockholm Convention Bureau, Box 6911, S-102 39 Stockholm, Sweden.

Committee on Problems of Drug Dependence — June 28-30, North Falmouth, Cape Cod, Massachusetts. Information: Martin Adler, executive secretary, CPDD, department of pharmacology, Temple University School of Medicine, 3420 N Broad St, Philadelphia, Pennsylvania 19140.

National Association of Alcoholism and Drug Abuse Counselors National Conference — June 28-July 1, Orlando, Florida. *The Magic of Recovery. Call for papers deadline: Dec 18, 1987.* Information: Carol Paquin, 3717 Columbia Pike, Ste 300, Arlington, Virginia 22204.

July

AADAC Institute on Addictions, Bridging the Gaps: Law Enforcement, Communities, Helping Agencies — July 3-6, Calgary, Alberta. *Supply and demand reduction: efforts and effects. Abstracts for concurrent sessions being accepted now.* Information: Tom Wispinski, conference chairman, Alberta Alcohol and Drug Abuse Commission, 7th fl, 10109 Jasper Ave, Edmonton AB T5J 3M9.

International Narcoties Research Conference — July 3-8, Albi, France. Information: J. Cros and J. Meunier, Laboratoire de Pharmacologie et de Toxicologie Fondamentales (CNRS) Toulouse, France.

5th Annual Plaza House Conference, Treatment and Prevention of Chemical Dependency in Adolescents: Individual, Family, and Community Approaches — July 16-17, Oakland, California. Information: Stephanie Ross, Meritt Peralta Institute Chemical Dependency Recovery Hospital, 435 Hawthorne Ave, Oakland, CA 94609.

35th International Congress on Alcoholism and Drug Dependence — July 31-Aug 6, Oslo, Norway. *Prevention and Control/Realities and Aspirations. International Council on Alcohol and Addictions (ICAA) and National Directorate for the Prevention of Alcohol and Drug Problems (NDPADP), Oslo.* Information: R.B. Waahlberg, or O.G. Aasland, NDPADP, Box 8152, Dept N-0033 Oslo 1, Norway.

August

International Doctors in Alcoholics Anonymous Annual Meeting — Aug 3-8, Baltimore, Maryland. Information: Joseph Chambers, 4001 Glenrose Ave, Kensington, MD 20795.

Australian Medical Society on Alcohol and Drugs: The Politics of Prevention — August 10-12, Hobart, Tasmania, Australia. Information: Jacob George, John Edis Hospital, Creek Rd, Newtown, Tasmania, Australia.

North American Congress on Employee Assistance Programs — Aug 14-17, Montreal, Quebec. Information: Diane Vella, director of special projects, 2145 Crooks Rd, #103, Troy, Michigan 48084.

Canadian Society of Hospital Pharmacists Annual Meeting — Aug 18-20, Toronto, Ontario. Information: Barbara Cole, CSHP, 123 Edward St, Ste 603, Toronto, ON M5G 1E2.

1st Canadian National Alcoholics Anonymous Convention — Aug 18-21, Halifax, Nova Scotia. Information: Conference coordinator, Box 1988, Halifax, Nova Scotia B3J 3M9.

September

7th International Commission for the Prevention of Alcoholism and Drug Dependency World Prevention Congress — Sept 4-8, Brisbane, Queensland, Australia. Information: Ernest

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Steed, 6830 Laurel St, NW, Washington, DC 20012.

39th National Conference on Alcohol and Drug Problems — September 23-26, Charlotte, North Carolina. Information: Alcohol and Drug Problems Association, 444 N Capitol St NW, Ste 181, Washington, DC 20001.

New York State Council on Alcoholism Annual Conference — Sept 25-27, Albany, New York. Information: Pamela Grant, NYSCA, 155 Washington Ave, Albany, NY 12210.

Annual Scientific Meeting of the Royal College of Physicians and Surgeons of Canada, the Canadian Society for Clinical Investigation, and Participating Societies — Sept 27, Ottawa, Ontario. Information: Anna Lee Chabot, RCPSC, 74 Stanley Ave, Ottawa, ON K1M 1P4.

Canadian Psychiatric Association 38th Annual Meeting — Sept 28-30, Halifax, Nova Scotia. Information: Lea C. Metivier, chief administrative officer, 294 Albert St, Ste 204, Ottawa, Ontario K1P 6E6.

October

International Symposium on Variability in Pharmacokinetics and Drug Response — Oct 3-5, Gothenburg, Sweden. Information: Swedish Academy of Pharmaceutical Sciences, Box 1136, S-111 81 Stockholm, Sweden.

American Association for Marriage and Family Therapy Annual Meeting: Family Therapy and All That Jazz — Oct 27-30, New Orleans, Louisiana. Information: AAMFT, Diane Sollee, conference director, 1717 K St, NW, Ste 407, Washington, DC 20006.

November

Geisinger National Conference on Addiction, Freedom 88 — Nov 2-6, Washington, DC. Information: Alan D. Hulsman, Geisinger Foundation and Marworth Alcoholism Treatment Center, Box 36 Lily Lake Rd, Waverly, Pennsylvania 18471-0036.

National Association of Social Workers Annual Conference: Choices and Challenges — Nov 9-12, Philadelphia, Pennsylvania. Information: Georgianna Carrington, NASW, 7981 Eastern Ave, Silver Spring, Maryland 20910.

22nd Annual Association for Advancement of Behavior Therapy Convention — Nov 17-20, New York, New York. Information: Mary Jane Eimer, AABT, 13 W 36th St, New York, NY 10018.

December

Southeastern Conference on Alcohol and Drugs (SECAD 88) — Early December, Atlanta, Georgia. Information: Charter Medical Corporation, Pat Fields, 577 Mulberry St, Macon, GA 31298.

Workshops/Courses

Editor's Note: Courses and workshops listed below are a sample of topics offered throughout the year. For more listings, watch* The Journal*'s regular monthly listings.

Demystifying Treatment of Cocaine Addiction — Jan 12, April 5, Center City, Minnesota. Information: Barb Thorsen, Hazelden, Box 11, Center City, MN 55012.

Making a Safe Place: Leading Alcohol and Other Drug Abuse Support Groups in Schools — Jan 18-22, March 7-11, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Pharmacology and Drug Abuse Distance (Correspondence) Course — Jan 20-April 20. Information: Addiction Research Foundation, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Double Jeopardy: Sexual Abuse Issues in Recovery — Jan 22-24, La Jolla, California. Information: Alcohol and Other Drug Studies, University of California, San Diego X-001, LaJolla, CA 92093.

Fundamental Concepts Distance Education Course — Jan 26-April 19, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Children at Risk: Alcohol and the Elementary Student — Jan 28-30, Milwaukee, Wisconsin. Information: De Paul Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Addictions Course for Health Professionals — Feb 5, March 4, and April 8, Ottawa, Ontario. Information: Betty Jones, Rideauwood Institute, 44 Eccles St, 2nd fl, Ottawa, ON.

Is It Chemical Dependency? Introduction to Screening, Diagnosis, and Assessment — Feb 11, Nov 28, Center City, Minnesota. Information: Barb Thorsen, Hazelden, Box 11 Center City MN 55012.

Practical Psychology for Pastors: Tools for Recognition of Addiction — Feb 15-16, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Effective Intervention Techniques: A Therapist's Perspective — Feb 20, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, Chemical Dependency Recovery Hospital, 435 Hawthorne Ave, Oakland, CA 946090.

Treating the Addictions: Getting Off and Staying Off — March 4-5, Boston, Massachusetts. Information: Judy Reiner Platt, The Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139.

9th Annual Employee Assistance Programs (EAP) Training Seminar — March 16-18, Charlotte, North Carolina. Information: William Cook, director, Metrolina Employee Assistance Programs, 100 Billingley Rd, Charlotte, NC 28211.

Implementing Prevention Programs, a National Workshop — March 22-25, Lake Arrowhead, California. Information: Tom Colthurst, University of California, San Diego, X-001, La Jolla, CA 92093.

Community Responses to Alcohol and Other Drug Problems — Apr 6-June 1, La Jolla, California. Information: Alcohol and Other Drug Studies, University of California, San Diego X-001, La Jolla, CA 92093.

Group Therapy for Adult Children of Alcoholics: Practical Considerations and Skill Development — April 21, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, Chemical Dependency Recovery Hospital, 435 Hawthorne Ave, Oakland, CA 94609.

Cocaine Abuse: Clinical Issues — April 25-26, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Youth, Alcohol and Drugs Workshop — May 5-6, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Alcohol and the Family Workshop: Community Program Approaches — May 16-17, Toronto, Ontario. Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Managing Problem Employees — May 17, Toronto, Ontario. Information: Jill Birch, program manager, conference and seminar services, Humber College, 205 Humber College Blvd, Etobicoke, ON M9W 5L7

Chemical Dependency and Eating Disorders: Common Denominators and Differences — June 11, Oakland, California. Information: Stephanie Ross, Merritt Peralta Institute, Chemical Dependency Recovery Hospital, 435 Hawthorne Ave, Oakland, CA 94609.

How Alcohol/Drug Dependence Affects Families — Aug 22-26, Minneapolis, Minnesota. Information: Johnson Institute, 7151 Metro Blvd, Minneapolis, MN 55435.

Chemically Dependent Women in the Workplace: Identification and Intervention — Oct 24, Center City, Minnesota Information: Barb Thorsen, Hazelden, Box 11, Center City, MN 55012.

Institutes

Pacific Institute of Chemical Dependency — Jan 4-16, Honolulu, Hawaii Information: Joyce Ingram-Clunn, Alcohol and Drug Abuse Branch, Box 3378, Honolulu, HI.

9th Annual Training Institute on Addictions — Feb 4-9, Clearwater Beach, Florida. Information: Institute for Integral Development, Box 2172, Colorado Springs, Colorado 80901

13th EAP Institute: A Management Training Institute for the Employee Assistance Program Specialist — March 20-24, Atlanta, Georgia Information: Irene Miller, Education Extension Services, Atlanta, GA 30332-0385

Annual Drug and Alcohol Spring Training Institute and Conference — April 4-8, Pittsburgh, Pennsylvania. Information: Nancy Sponeybarger, division of training and information services, Pennsylvania Dept of Health, Office of Drug and Alcohol Programs, Box 90, Harrisburg, PA 17120

2nd Pacific Institute on Addiction Studies — May 8-11, Langley, British Columbia Information: Karl Burden, Alcohol and Drug Concerns, 11 Progress Ave, Ste 200, Scarborough, Ontario M1P 4S7.

Institute for Alcohol and Drug Studies — May 23-27, Evansville, Indiana Information: Nadine A Condret, University of Evansville, 8800 Lincoln Ave, Evansville, IN 47722

20th Annual Southwestern School for Behavioral Health Studies — May 23-27, Tucson, Arizona. Information: Susan Villaescusa, program director, University of Arizona, 350 Wilmot, Box 12069, Tucson, AZ 85732.

Rutgers University Summer Session — May 31-June 24, June 27-July 22, July 25-August 17, New Brunswick, New Jersey. Information: The Summer Session, Rutgers University, New Brunswick, NJ 08903

New York State Summer School of Alcohol Studies — June 20-July 1, Ogdensburg, New York Information: Carolyn M White, Riverside Drive, Ogdensburg, NY 13669

Winter School in the Sun — June 27-July 1, Brisbane, Queensland, Australia Information: Bob Aldred, executive officer, Alcohol and Drug Foundation, Queensland, Box 320 Spring Hill, Australia 4004

29th Annual Institute on Addiction Studies — July 10-15, Hamilton, Ontario. Information: Karl Burden, Alcohol and Drug Concerns, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

17th Annual San Diego Summer School of Alcohol and Other Drug Studies — July 10-15, La Jolla, California Information: Tom Colthurst, UCSD X-001 La Jolla, California, USA, 92093

Summer School for Addiction Studies — July 11-29, Toronto, Ontario Information: School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1

The Johnson Institute Summer Training School on Alcohol/Drug Dependence — July 11-22 (Internship Week July 25-29), Minneapolis, Minnesota Information: Johnson Institute, 7151 Metro Blvd, Minneapolis, MN 55435

The Journal

AIDS: a community case study

Robertson: gradual changes

Skidmore: local ethos

British government campaign poster: high HIV infection rate prompted first needle exchange program

EDINBURGH — Scots explorers, educators, doctors, lawyers, missionaries, and colonists laid the foundation for what was to become the British Empire in Canada, the United States, and much of the rest of the world. More than 200 years after being forced into a United Kingdom, a fierce streak of independence remains. Scots naturally assume their systems of education, the law, and the sciences, especially medicine, retain their superiority.

Although high rates of spirits use are endemic, Scotland escaped the excess of the drug culture of the 1960s and 1970s. But, the country has been devastated in the 1980s by unemployment and an explosion of intravenous (IV) drug use. The high rate of HIV infection there led the central government in London to start Britain's first program of needle exchange to combat the threat.

A centre for the problem is the Muirhouse housing estate in Northwest Edinburgh (see also page 1). Muirhouse acquired international attention last year when Roy Robertson, MD, announced a 51% HIV infection rate among IV drug users, and the media national and international — descended. Dr Robertson fears a repeat in future.

Dr Robertson and Carol Skidmore, a psychologist who directs their Edinburgh Drug Abuse Study, and collaborators at Edinburgh City Hospital and Edinburgh University, constantly revise their data and submit reports to international conferences on AIDS and medical journals.

Life at Muirhouse is not easy, as they tell The Journal's **Contributing Editor** Harvey McConnell **in this the third in a series on AIDS in Europe: Switzerland and Denmark (The Journal, November), and the Netherlands (The Journal, October). Next month, Mr McConnell will report from Italy.**

The Muirhouse housing estate, built after World War II in a then upmarket sector of Edinburgh, avoided the architectural obscenities of postwar high-rises and concrete. It has neat green squares, houses, and apartment blocks no more than three stories high.

"But, gradually, as the city evolved, it ended up being the area nobody else wanted to go to, and there are quite a few problem families," Ms Skidmore explains. "Young people using drugs have lived here all their lives.

"We see kids whose fathers and mothers smoke 60 cigarettes a day and drink, and around them is some kind of dependence. Yet, while there are one or two families (in which) you can look right down the line and see exactly what is coming, on the whole, most are not too problematic."

Because Muirhouse acquired a certain isolation, now solidified by the high rate of IV drug use in the 1980s and the rapid spread of HIV infection, Dr Robertson and his 10 fellow general practitioners have a unique community in which to follow the progression of HIV infection and the conversion to AIDS related complex (ARC) and AIDS.

The 1986 outburst of international interest in Muirhouse has subsided: but only for the moment. "Things are going to hot up again, there is no doubt about it. And, it is very difficult to know how we are going to cope with that," Dr Robertson says. "We have individual disasters, such as 15-year-old girls in unprotected sexual relationships with drug users, and phenomenal problems and potential disasters."

Even so, the first case of AIDS diagnosed on the estate this fall came as a real shock. "Everybody on the estate knows this girl has AIDS," Ms Skidmore says. "And it has shocked the drug-using kids, even though as a group they see members die quite regularly: there have been three deaths this year, two girls from overdoses, and one man from hepatitis."

Ms Skidmore's updated statistics show that among 5,500 patients in the 16- to 30-year-old age group, 260 have a history of heroin use, as well as amphetamines, or "anything which comes to hand." Other drug use has risen in wake of police and customs crackdowns on the heroin supply.

Patients who were heroin addicts were outside Dr Robertson's medical reference when he joined the practice eight years ago.

"We knew there were only about 50 injectors in Edinburgh in the 1970s. By 1982, it was estimated there were between 2,000 and 3,000 IV heroin users here."

By that time, Dr Robertson and his colleagues knew, because of hepatitis cases, there was a lot of needle sharing. Then, AIDS appeared in the United States.

Dr Robertson recalls that in 1983, "I gave a lecture to some of my colleagues and, being rather provocative, said, 'If you don't do something about it now, you are going to have an AIDS problem within two or three years' — but not really believing ourselves we really would.

"Ironically, at that time there was an AIDS problem: though invisible then, it was spreading. That is when it landed in this group and spread rapidly."

Ms Skidmore adds that in the city, then, "intravenous drug use was chaotic." (It is one of the few activities in Britain to surmount the notorious class barriers, with rich and poor alike shooting, sharing, and dealing.)

Although Dr Robertson and Ms Skidmore do their best to educate, advise, cajole, and counsel, the activity of many patients can be depressing in the extreme.

Ms Skidmore: "The ethos in this part of the country is that the girls want to have a baby so they can get a house of their own. They won't use the pill, won't use condoms, won't use any kind of contraception. The only thing that has been used with any kind of success is the injectable contraceptive Depo-Provera — which you usually associate with Third World countries — but even then, they forget to turn up for their boosters.

"Many girls are quite content to have a child by the time they are 16 or 17, to have three by the time they are 20, and to be sterilized when they are 25.

"We have women who are sero-positive who say; 'You told me the first time I had a baby it would be sero-positive and develop AIDS and die. Look at her, she's fine, she hasn't even got the virus. I am going to have another one.'

"A lot of men say: 'In three years, I might die of AIDS, and I want to have a baby now. Why should I wait?'

"Their behavior is very immediate. Everything is done for the minute. They will share needles with somebody who is infected just because they want a shot; they will have sex with somebody without using a condom because they want to. They don't think about consequences or plan ahead.

"Also very depressing is the thinking of people who have been HIV-positive for five years, still show no symptoms of ARC, and their sexual partners don't have symptoms. Nothing has happened as yet, so they think they are not infected and don't have the virus, and they think things are going to carry on being as they are now."

The next few years are going to be a trying time for the estates, for the doctors, and for their staff. "I think there is going to be an increasing panic among local people. There is going to be anxiety, and there are going to be people choosing not to come to this facility any more, which is a great regret," Dr Robertson declares.

"My view is that we can do nothing about it: we can't say we are not going to treat patients who have AIDS."

Despite the fact that young people are still taking drugs, there are changes, and they have been monitored. Dr Robertson: "There is no doubt in our minds that things are changing gradually. The shooting gallery phenomenon has gone. People are saying they wouldn't share with anyone who is sero-positive, or whom they thought sero-positive; they wouldn't share with anyone they didn't know; and, they wouldn't use works they did know had been used before. These are gradual changes on different parameters.

"But they do share with their sexual partners, and if you really push them, they will admit, that, well, on occasions they have shared with somebody else. In a way, this is inevitable: you are not going to get it perfect straight away."

Two important other factors in HIV infection and AIDS fortunately don't complicate the picture in Muirhouse. There are no hemophiliacs and, if there are any practicing homosexual males, they are well hidden. Ms Skidmore was told forcefully by one addict that he wants it inscribed on his gravestone he was a junkie "because I don't want anybody to think I was a poof."

However, a few addicts are so aggressive, with undertones of violence, that serious consideration is being given to removing them from the practice roster.

Ms Skidmore is blunt: "They won't ever find a doctor in Edinburgh so sympathetic as the doctors in this practice, but having said that, there is a limit to how much aggression and violence the staff are prepared to put up with."

A footnote: *A taxi driver had waited patiently for more than 20 minutes outside the clinic. The meter was not running. "Was that* that *Dr Robertson with you?" he hurried. Told that it was, he added: "Aye, he's a good doctor."*

The natural history of drug addiction

EDINBURGH — Roy Robertson, MD, in the tradition of Scots medicine, has been launched on a path he did not choose, but down which he now intends to go much, much further.

Dr Robertson: "My interest is drug abuse, rather than AIDS (see above story). We now have a study underway into the natural history of drug addiction; to some, it might sound boring, and people have said, 'Oh yes, but what about AIDS?'

"But it isn't boring. It has tremendous implications for AIDS, which, after all, is a manifestation of, among other things, drug abuse. I still think we need more information about what happens to drug users, about what makes them start, what makes them stop. Because I don't think fear of AIDS changes anything.

"I don't really believe down inside that people really are not going to start using drugs because AIDS is around now. People are still starting to use."

However, he adds, as morbidity and mortality of AIDS increase, there will be an impact on their continued use of drugs, their stopping using drugs, and on their social lives and their families.

"I think it is just as fascinating to study the sero-negatives as it is to study the sero-positives," he adds.

He believes "the people who are most at risk are those who have just started to use drugs, who don't have any doctors, and don't have contacts with agencies. I am interested in early intervention."

In a way, "it is a cheap option" just to throw money around to set up methadone maintenance programs, especially as those who will attend will be long-time addicts.

"We need large amounts of resources for drug use and not just for AIDS. At the moment, a lot of empires are being built all over the place for AIDS, and the bottom line is that nothing is being done about drug abuse."

NATIONAL FORUM

Return to Native traditions works

By Joan Hollobon

WINNIPEG — Native people increasingly are taking responsibility for their struggle against alcoholism and drug abuse, deriving strength from turning back to their traditions and culture.

Theresa Strawberry, chief for eight years of the 400-member O'Chiese Band at Rocky Mountain House, Alberta, told a workshop at the National Forum on Drug Awareness here, attempts to improve her band's situation failed despite improved housing and education, and even more money.

Chief Strawberry recognized alcoholism was the biggest problem. She also "realized I had to go into treatment."

Before the next band council election, she got council to pass a resolution that all band leaders would have to have treatment or stay sober; she announced this was to be her major project if re-elected.

Returned to office with a big majority, Chief Strawberry and the council went to Edmonton for alcoholism treatment, hired a new program director and new social worker, and worked for a year to bring mobile treatment to the reserve: "People with eight kids can't go away for treatment."

Having treatment available on the reserve turned it into a community project that provided mutual support for participants, both men and women, ranging in age from adolescents to people in their 60s. In some cases, whole families went through treatment together.

The Alkali Lake Band at Williams Lake, British Columbia, pioncered community effort to combat alcoholism through initiatives by band leadership some 15 years ago.

Charlene Belleau, band program coordinator, told **The Journal** a film on their experience has been shown at more than 100 conferences and workshops all over North America and is being used now as a model to help other Native groups set up similar programs.

"The key to our success is that our leaders are the ones who set the example, they are the role models. From there, it spread to the administration, where we were required to be sober."

Ms Belleau has been sober for eight years now: "Everyone in the community was affected at one point or another. Once the first few sobered up, it just had a rippling effect that caught on with the whole community, and we all pulled together."

The most successful of the ongoing Native programs still are those run by volunteers. Programs run almost every night — Alcoholics Anonymous, Adult Children of Alcoholics, Survivor groups for those who have suffered child or sexual abuse, and separate women's and men's Sharing Circles.

Weekend recreational events, such as hockey games, also are dry: "We just make sure everything we do does not involve alcohol," Ms Belleau says.

Alcohol is not banned, but none is sold on the reserve and most of the community now is dry.

Ms Belleau says education plays a major role in preventing children from turning to alcohol — "both education in the learning sense and education about alcoholism." Right from day care to high school, children have their own Sharing Circles and learn about alcohol.

"When they start talking, they start knowing who is sober and who is not. They know alcohol is not a part of Alkali, and when they recognize it outside of the community, they know what it is and that it is not the way we are."

Drug Awareness
A NATIONAL FORUM

The 425-member Alkali Band still has economic problems and unemployment, but hopes to set up a training and treatment centre for alcoholism to serve Native people from Canada and the United States. The centre will employ 25 to 30 people.

"I think these things are falling into place. The key issue is that we developed people first. All over the country, not only with Natives, we hear the prime minister, the chiefs, and leaders saying, 'If only we had economic development, people wouldn't be out drinking; if we had nice houses they wouldn't be on the streets.'

"To us, all these are excuses for not really dealing with the problem of alcoholism."

Ms Belleau says the second key to the Alkali Band's success is that the band accepted responsibility for their community.

"We didn't wait for the (federal department of) Indian Affairs or National Health and Welfare or anybody to solve our problems. We found solutions from within the community, and that is really important."

Paul Andrew of Inuvik, Northwest Territories, a broadcaster with CBC (Canadian Broadcast Corporation), also told the workshop of a return to Native customs. Active in a Friendship Centre and in rehabilitation projects at Inuvik, Mr Andrew said his people are getting back to drum dancing and are learning the Slavey language again. On weekends, groups are going out onto the land, fishing and hunting and "concentrating on staying sober.

"We have a good time in the bush talking about old times and listening to the elders who are re-introducing our cultural background. People had lost the traditional way of life, but now we are getting back to an older lifestyle."

Among other Inuit communities, too, the emphasis is slowly shifting to a return to older values and traditional reliance upon the elders.

Jens Angaangaq Lyberth is owner-operator of a travel agency at Iqualuit (formerly Frobisher Bay). He heads Tuvvik, the local alcohol and drug committee, and is also working to bring the elders into the fight against alcohol, drugs, solvents, and suicide.

"How can a community of 3,000 people drink 2,800 cans of beer a day — one million cans a year — plus wine and liquor?" he asked the workshop.

He said $40,000 worth of hashish enters Iqaluit every month, and glue-sniffing is rampant, with younger and younger children suffering withdrawal symptoms from solvents.

Children form 52% of the Iqaluit population, and represent 98% of suicides there.

The traditionally tight-knit Inuit community has become disrupted over the years in Iqualuit, but now "we are the first group in the Eastern Arctic to consult the elders about alcohol."

The drum, with its deep spiritual significance, is coming back. Survival depends, he said, on the Inuit "learning these traditions and recognizing we are spiritual, not just physical, beings."

Later, Mr Lyberth, who has been studying the drum for about 10 years, performed for a hushed audience at a plenary session.

Recently, he flew over the now abandoned Greenland community where he spent his early years: "It was a beautiful place. Sometimes I'd much rather be Joe Blow Eskimo who lives in the North — a peaceful life, like my parents had — a beautiful life, living off the land," he told **The Journal**.

Instead, he is now a vocal leader in Iqualuit, entering the struggle against addictions.

Iqualuit's municipal government is beginning to recognize the role of the Inuit elders in village life, and Mr Lybeth says he looks to the day when similar recognition comes from the Northwest Territories legislative assembly.

Some Northern situations sound remarkably like those of any city suburb in Canada. Annie Kellogok, a young woman from Coppermine, who overcame her own alcohol problem six years ago, is particularly concerned with the women — at home, drinking, and loath to admit it. Also, there is a great deal of hidden spousal and child abuse, she said.

The Native delegates, particularly, welcomed the conference: "What I like is the networking going on," Charlene Belleau told **The Journal**. "But I also believe . . . there has to be follow-through on the recommendations."

NNADAP encourages dialogue

The theme *Keep the Circle Strong* grew out of the Western Arctic Peer Group, a committee representing six communities in the Western Arctic and one in the Eastern Arctic.

It was designed into a logo by the government of the Northwest Territories (NWT) and the NWT region of the National Native Alcohol and Drug Abuse Program (NNADAP). This was further adapted for November's National Addiction Awareness Week.

NNADAP director Richard Jock told The Journal programs generated within communities, such as those in the accompanying article, are "excellent illustrations of what communities can accomplish, given the motivation." He said the Alkali Lake Band, for example, "has inspired people across North America."

Although NNADAP provides occasional project-funding assistance, Mr Jock said: "I see our role as one of promoting models such as these, and encouraging interchange among bands and other groups to further motivate others."

Alkali school principal — one success story

By Deana Driver

REGINA — Eleven years ago, Freddie Johnson would just as soon have knocked you down as said hello to you. He almost killed his own father during one drunken binge — one he doesn't remember.

Today, Mr Johnson is principal of the Sxoxomic school on the Alkali Lake Indian reserve, Williams Lake, British Columbia.

He spends much of his spare time talking to groups about the successful recovery process the Alkali band used to regain control of their lives and their pride.

At a recent Native health conference here, Mr Johnson said he'd hit rock bottom, been in accidents and been near death a few times because of his drinking, without realizing the effect of the alcohol.

His story is included in a film *The Honour of All* on Alkali Lake, a community that went from total alcoholism to 95% sobriety (see story above). His parents are shown at the hospital, amazed at the wounds he inflicted on his father. At the end of the film, Mr Johnson cries when he talks to band members about that experience.

Johnson: through hell

"That's the way I was when I was drinking, and I didn't know what the hell was going on. I didn't know that alcohol was doing that to me," he explains.

Mr Johnson learned, from an intensive Alkali training course, to have patience and hope. "It was people who helped me, and it's my turn to help people," he says.

"We use our culture to heal our people:" the sweatlodge, Native dances, and regular meetings of men's and women's groups on the reserve; each helps to build and maintain a sense of pride and identity for the people.

"I come from a community that really went through a lot of hell," he says, and many other North American communities are going through the same.

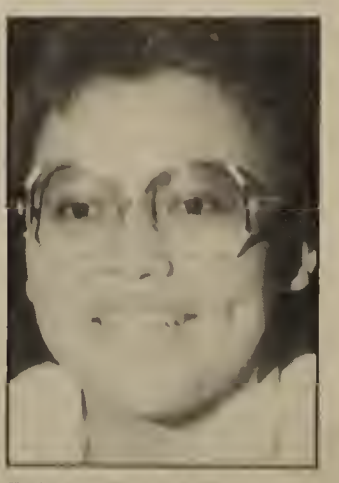
Making the film about Alkali Lake and speaking to groups has served an important purpose: "What the film has done is bring it out in the open, and say, 'You can help these people, and there is hope for these people.' "

Lyberth: consulting elders

Kellogok: hidden abuse

Strawberry: realization

Andrew: traditional way



Belleau: ripple effect

INTERNATIONAL

Government leads war on smoke in Singapore

By Lachlan McQuarrie

SINGAPORE — The anti-smoking campaign here is in many ways similar to other Singapore campaigns — to discourage spitting, to promote cleaner streets, to use Mandarin in preference to regional Chinese dialects — with the government leading the way, rather than reacting to public opinion.

The national non-smoking control program wasn't triggered by any large scale public concern about smoking or by the activities of an anti-smoking lobby.

But in December, 1986, the government took action, with the official campaign slogan, *Towards a Nation of Non-Smokers*. Health Minister Richard Hu said the long-range objective is to "promote non-smoking as the norm in Singapore.

"We are optimistic that in a decade's time, the rate of smoking will be half that at present."

It is estimated that only 12.5% of the total population here, or 19% of those more than 15 years old, smoke. That is approximately 325,000 of 2.6 million people and not particularly high by Asian standards.

Songs and slogans used in the campaign have emphasized patriotic themes: "It's unpatriotic to smoke." There has also been an attempt to make smokers feel isolated and ashamed by stressing the dangers of passive smoking and reminders of the Confucian concept of placing the welfare of society above the individual.

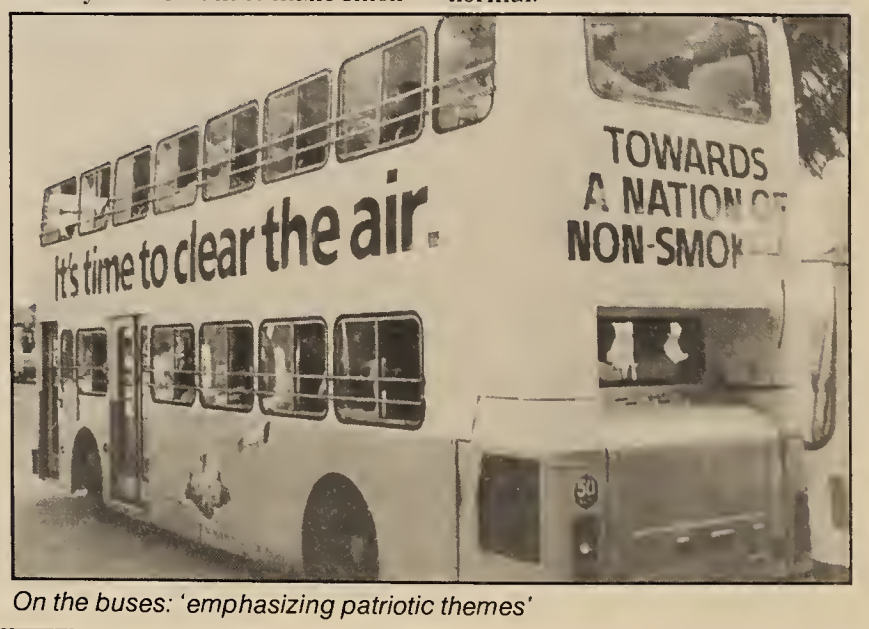
There is a National Smoking Control Coordinating Committee with a budget of $1.7 million dollars (Cdn $1 million) and representatives from the ministries of health, communications and information, defence, education, environment, labor, and trade and industry. Labor and management also participate through the National Trade Union Congress and the Singapore Employers' Federation.

One of the most intensive anti-smoking campaigns is being carried out in the Singapore Armed Forces (SAF). In addition to smoking cessation classes, operated throughout the SAF by doctors and counsellors from SAF medical services, a study is being launched to see what smoking does to a military person's ability to wage war.

The tobacco industry here has reacted by downplaying the dangers of passive smoking and trying to raise the spectre of "unwarranted government intrusion into people's lives." The Singapore Tobacco Manufacturers and Importers Association has sent organizations involved in the anti-smoking campaign copies of a report criticizing the methodology of passive smoking studies.

So far, the government has not indicated stringent laws limiting smoking will be introduced. Luisa Lee, education director for the ministry of health, describes smoking as "a personal preference" and stresses that the emphasis will continue to be on discouraging smoking.

"We're trying to create a climate not conducive to smoking," she says. "We want to make smoking very inconvenient and to explain that it is not condoned and not normal."



On the buses: 'emphasizing patriotic themes'

One Singapore anti-smoking song includes these lyrics:

Hey there Singapore, it's time to clear the air.
Come all you smokers, show us that you care.
We know that there's a problem and quitting can be tough,
But, we're sick of the smoke, sick of the smell,
And, we think you've had enough.

We're an independent nation of people on the go,
And we need every one of you to help our nation grow.

Technicalities trip up DWI drive

By Karen Birchard

DUBLIN — Irish authorities are trying to plug a newly discovered loophole that has allowed thousands of drunk-driving charges to be dismissed and opened the floodgates for appeals by those recently convicted.

The judicial mess comes at a time when police have stepped up the drinking/driving campaign, and it is the second time in less than a year that drunk-driving charges have been thrown out of court on a technicality.

This time, charges are being dismissed because of the wording on the form describing results of a defendant's blood or urine test. Irish law requires this form to be entered as evidence, but, a High Court Judge recently ruled the wording on the form did not comply with the law.

The form states that it is "to be issued" under the Road Traffic Act when it should read that it "is issued" or "has been issued."

"It's ridiculous," said a campaigner against drinking and driving, "unbelievable that a simple grammatical error could result in drivers whose blood-alcohol content was well above the limit just walking out of court."

The director of public prosecutions has lodged an appeal with the Supreme Court to try to salvage thousands of proceedings for drunk driving. A ministerial order has been issued to change the wording.

Earlier this year, thousands of traffic-offence summonses were struck out by district justices because the summonses had been issued by a computer instead of being considered by district judges.

Emergency legislation was passed to bring judicial proceedings into line with the new technologies, but many cases, including a large number of drunk-driving summonses, are still under appeal.

GILBERT

Municipal actions: I

My loose association with Ontario's Addiction Research Foundation and my work as a municipal councillor sometimes intersect, most often in matters to do with smoking. Then I get the chance to put my vote where my pen is and even to initiate things.

Occasionally I act at City Hall in ways that the drug abuse community might not favor. An example was a recent, unsuccessful attempt to replace a resolution supporting the federal government's proposed Tobacco Products Control Act (Bill C-51) with one calling for updating and enforcement of the Tobacco Restraint Act.

The restraint act forbids the possession or use of tobacco products in a public place in Canada by anyone under the age of 16 years. The maximum penalty on first conviction is a reprimand; on second conviction, a fine of $1; on third and subsequent convictions, a fine of $4. No charge has been laid for decades.

Bill C-51, if enacted, will ban all forms of tobacco advertising and most promotion of tobacco products. It will also do sensible things: cigarette packs will carry stronger warnings; manufacturers and importers of tobacco products will have to provide more information to government about the toxicity of their products.

Favored action

Action of mine at City Hall that has met with more favor concerns smoking in the workplace. Early in 1984, I proposed to Toronto's Board of Health (which acts as a committee of the City Council) that Toronto move to restrict workplace smoking.

The time was ripe. A tortuous four-year attempt to restrict smoking in restaurants was nearing fruition, leaving the way clear for other action. San Francisco's innovative ordinance had just received confirmation by plebescite: it sought to encourage the adoption of workplace smoking policies satisfactory to both smokers and non-smokers. Nevertheless, only now is a bylaw about to be passed that restricts smoking in Toronto's workplaces (see table).

The main reason for the delay was the need to secure approval of the provincial legislature to pass a bylaw of the kind in effect in San Francisco.

Ontario-wide action will be a mistake if it impedes use of the most important requirement — that workplace smoking policies be developed through negotiation between smokers and non-smokers

The San Francisco ordinance requires each office employer to establish a policy respecting smoking that is satisfactory to smokers and non-smokers. If agreement cannot be reached, smoking must be banned.

Arbitrary rules

Such legislation involves a degree of delegation of responsibility for enforcement that is ordinarily beyond the power of municipalities in Ontario. Moreover, it involves potential arbitrariness in the rules for smoking and not smoking that is also beyond municipal authority to prescribe.

The City of Toronto's lawyer advised that the City had the power only to ban smoking completely in every workplace of a particular kind or to require that a uniform proportion of space be set aside for smoking. To follow the San Francisco model, which was considered desirable, enabling provincial legislation was required.

Further reasons for the delay were the need to study the experience of other municipalities, particularly San Francisco, and a change in direction during the process that was occasioned by the nature of the enabling legislation — it permitted the City to limit smoking in all workplaces (except those of the provincial and federal governments), even though the additional authority had been requested only in respect of office workplaces.

Except that all workplaces are covered, the proposed Toronto bylaw follows the San Francisco ordinance closely. Implementation will be different, however. The Toronto public health department has concluded that the rate of compliance with the San Francisco ordinance is only 50%, and that only 30% to 40% of workers are aware of the ordinance.

The Toronto bylaw will be launched with a large publicity campaign. Four inspectors will be hired for a year to ensure that education and enforcement occur. The sum of $530,407 is being budgeted to cover these additional costs during the first year of the bylaw. The maximum fine for employers and employees who contravene the bylaw will be $2,000.

Province-wide law

Other Ontario cities are moving in the same direction, including two of Toronto's neighbors, Etobicoke and York. Recently announced plans by Ontario's new provincial government may stall further municipal action in this area. Province-wide legislation is to be introduced during the next year. Reports of comments by Greg Sorbora, Ontario labor minister, suggest that the San Francisco model will not be followed.

Province-wide action will be a mistake if it impedes use of the most important requirement of the San Francisco (and Toronto) legislation — that workplace smoking policies be developed through negotiation between smokers and non-smokers. The alternatives — to ban smoking outright or to limit it according to a province-wide formula — could meet with damaging resistance. Legislators should tread carefully and recognize both the great variation among workplaces and the large amount of each day that workers spend in them.

Next month, I'll write about another opportunity for municipal action: preventing sales of cigarettes to children.

Events leading to passage of Toronto workplace smoking bylaw

Jan 84 — Proposal made to the Board of Health.

Apr 85 — Board of Health recommends adoption of the proposal.

May 85 — City Council endorses proposal and votes to seek enabling legislation.

Dec 86 — Provincial legislature grants power to Toronto Council to limit workplace smoking.

Anticipated

Nov 87 — Board of Health recommends adoption of a bylaw.

Dec 87 — City Council passes bylaw limiting workplace smoking.

Mar 88 — Bylaw comes into effect.

By Richard Gilbert

HOWELL

Some sins are more deadly

When I dropped by my friend Professor Bottomsworthy's office last week, I found him trying, unsuccessfully, to insert a copy of the recent House of Commons Standing Committee on National Health and Welfare report on alcohol and drug abuse into the top shelf of his bookcase. He was attempting to wedge it between a yellowing copy of the United States Surgeon General's report on smoking and the Lalonde report on preventive health strategies, and it wouldn't fit; the shelf was full.

"Why don't you just put it on one of the other shelves," I suggested, "since the rest of them are virtually empty."

"Of course they're virtually empty," growled the professor, as he banged the Commons Committee report in with his fist, "and they will remain empty as long as our governments and social scientists are obsessed with Gluttony. Look at this top shelf — it's filled with fact-filled, statistics-stuffed reports and publications that quantify the deleterious effects of glutting our bodies with legal and illegal substances.

"I've had it up to here with Gluttony. When do we ever hear about the other deadly sins that preoccupied the medieval mind, deadly sins that still cause more discontent and pain and suffering in a week than Gluttony does in a year?

"Where are the serious scientific inquiries to fill up these six empty shelves? Has there ever been a Senate inquiry into Sloth? Has there ever been a Commons Committee report on Avarice? Has there ever been a Royal Commission on the deleterious effects of Pride? When was the last time you heard of a US Congressional Committee investigating the social costs of Envy? Has the World Health Organization ever organized an international symposium on Lust? Has the United Nations ever seriously examined the effects of unbridled Wrath?

"Oh no, it's always Gluttony — we eat too much, we drink too much, we smoke too much, we pop too many pills, and so on and so forth. It's true of course, but where is the perspective? Just because these things are relatively easy to quantify by way of surveys, questionnaires, mortality and morbidity statistics, and what not, it does not necessarily follow that Gluttony should be the deadly sin that captures the sole attention of our legislators.

"Consider Pride. Where was the US Senate Committee on Pride after the Cuban missile crisis almost got us all blown up in a nuclear holocaust? How come earnest representatives from governments are always going to Vienna or Geneva or wherever to discuss Gluttony-associated problems, when it is Pride that got thousands of young Yanks killed in Vietnam, that is getting thousands of young Soviets killed in Afghanistan, and it is Pride that is wasting a generation of Iraqis and Iranians?

"Consider Avarice. In late October, 1987, the stock market crashed and speculators, investors, pension-funders, and the proverbial widows and orphans lost millions. Did we get a Royal Commission? Did the US Senate look into the deleterious effects of Greed? No, we got the usual, if we got anything at all — some committee on obesity or alcoholism or some other aspect of Gluttony.

"Consider Envy. Every year more money is spent on fancy cars, useless kitchen appliances, designer jeans, Jacuzzi tubs, and video cassette recorders than is spent on crack and smack and other uppers and downers. Despite that, scores of social scientists are working on ways to document and quantify use of the latter substances and not one working to quantify the social cost of Envy, and the Avarice it inevitably leads to.

"Consider Lust. Lust can collapse financial empires and destroy noble aspirations — ask Jim Bakker and Gary Hart. Preliminary calculations show Lust results in more time off work and more at-work goofing-off than all the Gluttonies put together.

"But until AIDS came along to make Lust research fashionable, social scientists wouldn't be caught dead devising ways and means of calculating the social costs and consequences of Lust. When was the last Congressional Committee on Lust, a committee that might have determined that while we, with the help of our European allies, were devising the ultimate, phallic shaped bottle to dispense over-advertised perfume at over-inflated prices, the Japanese were perfecting the ultimate computer microchip?

"Consider Sloth. Sloth results in more time off work and in more lost productivity than all the Gluttonies combined.

"Preliminary research shows that for every worker who does not make it to work because of an alcohol-induced hangover, there are at least five workers who do not make it because they are too lazy to get out of bed. It's called, in the vernacular, a 'mental health day,' but it is Sloth, pure and simple.

"Why is the Sloth shelf of my bookcase as empty as the Pride, Avarice, Envy, Wrath, and Lust shelves? Where is the Committee on Sloth? The National Forum on Sloth Awareness?

"Why this obsession with Gluttony? If our economy goes down the tube, it will go down because of Avarice and Sloth, not because of Gluttony; and if we all go up in a mushroom cloud, it will be because of Pride and Wrath, not because of Gluttony. With all due respect to Gluttony, some sins are more deadly than others."

By Wayne Howell

New Books

by Margy Chan*

The Alcohol Clinical Index: Strategies for Identifying Patients with Alcohol Problems

. . . Harvey A. Skinner and Stephen Holt

The Alcohol Clinical Index is a versatile instrument developed for physicians and allied health care professionals to identify alcohol problems among patients. It was derived from a comprehensive analysis of 18 clinical laboratory tests that are potential indicators of alcohol abuse.

The 31-page booklet describes a practical strategy for using the index and suggests methods for corroborating it with laboratory tests and brief alcohol questionnaires.

Addiction Research Foundation, Toronto, Canada, 1987. 31 p. ISBN 0-88868-144-5

AIDS: Impact on Public Policy

. . . edited by Robert F. Hummel, William F. Leavy, Michael Rampolla, and Sherry Chorost

Acquired Immune Deficiency Syndrome (AIDS) has become a major concern to research and health care communities. Initial attention to the disease focused on its epidemiology to define the nature and extent of its threat. As the disease spreads into epidemic proportions, it raises not only medical and research issues, but also social, economic, and moral dilemmas.

The impact of AIDS on public policy on national as well as international levels is now evident.

This volume is the result of an international symposium held in May, 1986 in New York and includes major papers presented there as well as panel discussions. Social scientists, researchers, clinicians, educators, community leaders, government officials, and public policy analysts contribute.

Plenum Publishing, New York, NY, 1986. 169 p. $45. ISBN 0-306-42540-8.

**Margy Chan is manager of the Addiction Research Foundation's library, the leading library in the field worldwide. A graduate of the University of Hong Kong, she holds a master's in library science from the University of Toronto.*

ON SCREEN

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Criss Cross

Number: 814.
Subject heading: Alcohol and the family: youth and drugs.
Time: 40 min.
Synopsis: Claudia Black and Scott Marshall show various situations commonly occurring in families in which a teenager uses drugs. A progression of scenes show the teen attempting to explain drug use and the parent responding with ever increasing confusion, anger, and fear. The importance of professional help in such situations is stressed.
General evaluation: Very good (5.0). Although the people in the film talk quickly, the scenes portrayed are believable and could lead to good discussion about family problems. General broadcast is recommended.
Recommended use: With a resource person, the film could benefit parents and health professionals.

The Cocaine Epidemic

Number: 815.
Subject heading: Cocaine; drug use, etiology, and epidemiology.
Time: 30 min.
Synopsis: To explain today's cocaine 'epidemic,' a lecturer tells about cocaine use throughout the 1800s and 1900s. He attributes use in the late 1800s to Sigmund Freud, who used it to treat morphine addicts. After the passage of the United States Harrison Act, cocaine practically disappeared; it reappeared after the film *Easy Rider* came out. At first, there were few clinical problems; now it is considered a major drug problem. The lecturer outlines many social and physical problems surfacing in the 1980s as supplies of high-quality cocaine become readily available.
General evaluation: Poor (2.1). The lecturer is boring, and the visuals are difficult to read.
Recommended use: This film could be used by someone interested in a historical perspective on cocaine.

Too Dangerous To Work With

Number: 817.
Subject heading: Employee assistance programs (EAPs).
Time: 24 min.
Synopsis: Billy Carter comes to talk to railway yard workers about using drugs on the job. After he leaves, several men discuss what they can do about workers who drink and smoke marijuana on the job: they do not want to tell on fellow workers, but neither do they want to get hurt. At work over the next few days, the men discuss what they might do about workplace drug use and talk to the men involved. They do not seem to get anywhere. Each day, trains are shunted around the yard, and each time there is a possibility of someone getting hurt. At the end, the man most concerned is run over by a train because a user is too spaced out to respond to radioed commands.
General evaluation: Very good (5.2). This believable, well-produced film could lead to good discussion about safety on the job and the role of EAPs. The tension is well developed right up to the end. General broadcast is recommended.
Recommended use: With a resource person, the film would benefit workers, supervisors, and safety committees.

"I want this man tested for steroids"

Coming Events

For full listings of 1988 conferences, workshops, and institutes, see the centre section.

SECAD 1987 (Southeastern Conference on Alcohol and Drugs) — Dec 2-6. Atlanta, Georgia. Information: Charter Medical Corporation, addictive disease division, Box 209, Ste 701. Macon, GA 31298.

International Conference on Alcohol and Industry — Dec 3-5. Medellin, Colombia. Information: SURGIR and International Council on Alcohol and Addictions, Apdo. Aereo 10199. Medellin, Colombia.

Countermeasures 87 — Dec 6-8. Toronto, Ontario. Information: Countermeasures 87 conference, Drinking Driving Countermeasures Office, Ministry of the Attorney-General, 10 King St E, 8th fl. Toronto, ON M5C 1C3.

Management for Health Care Supervisors — Dec 11-12. Halifax, Nova Scotia: Dec 15-16. Toronto, Ontario: Jan 13-14, 1988. Vancouver, British Columbia: Jan 15-16, Calgary, Alberta. Information: Conference and seminar services, Humber College, 205 Humber College Blvd. Rexdale, ON M9W 5L7.

Acupuncture in the Treatment of Alcoholism and Other Drug Dependence — Dec 17-18 (School for Addiction Studies) and Dec 19 (Ontario Institute for Studies in Education). Toronto, Ontario. Information: Addiction Research Foundation, School for Addiction Studies, 8 May St. Toronto, ON, M5S 2S1.

Toc Alpha's 31st Annual Christmas Conference — Dec 27-30. Toronto, Ontario. Information: Michelle Amez and Michael DeGagne, Toc Alpha, 11 Progress Ave, Scarborough, ON M1P 4S7.

Careers

Prevention: are we on track?

'When we kneel at the altar of feeling good, I think implicitly we set kids up'

ST LOUIS — Focussing all prevention resources on young people may be "a strategic public policy mistake," says the provocative Peter Bell, executive director of the Minnesota Institute on Black Chemical Abuse in Minneapolis.

"I think sometimes in our prevention programs essentially what we do is put Little League baseball in competition with cocaine. I think cocaine feels better."

Mr Bell reviewed prevention programming theories here at a plenary session of the Alcohol and Drug Problems Association (ADPA) of North America. Highlights, edited by Contributing Editor Harvey McConnell, **follow.**

"The first question is: do we want to prevent alcohol and other drug abuse, or do we want to prevent alcohol and drug abuse problem events? In reality, I feel most of us want to prevent both. The strategies to prevent each, however, might look quite different.

For example, strategies to eliminate drunk driving do not necessarily have to focus on reducing alcoholism. In addition, we need to understand that there are only three basic relationships individuals can have with any psychoactive substance. They can use it, they can abuse it, or they can become dependent upon it.

Most of us accept that with alcohol the goal is to prevent abuse by, and dependency in, adults; with other drugs, it is to prevent use, abuse, and dependency by everyone. The strategies to prevent either alcohol or drug use, abuse, or dependency might vary significantly.

I have divided prevention programming into four separate subgroups: social competency, social policy, law enforcement, and nutritional and chemical imbalance.

> ***'The emphasis on alternative highs rather than on legitimizing lows is a mistake'***

Social-competency prevention I define as the reduction of alcohol and other drug use via the development of skills and knowledge essential to day-to-day living in five areas; most prevention programming endorses one or more of these strategies in concert with one another: clarify values, build good emotional coping skills, make good decisions, develop alternative highs, and develop good communication skills. I would add a sixth — develop refusal skills.

A second prevention strategy, one I am somewhat more attracted to, is social-policy prevention. It is much more an anthropological or socio-cultural view and approach to addiction and prevention and an emerging concept of looking at alcohol and drug abuse.

A third is law enforcement and focussing on supply reduction, the theory being that if we can contract or restrict the supply, fewer people will use alcohol or drugs. There is a fair amount of truth to that, particularly using market mechanisms.

Studies have indicated clearly that when the price of alcohol increases, even hardened alcoholics drink less, and, when the price of drugs increases, even hardened addicts use fewer. The biggest impact this has is on marginal, episodic users of drugs.

The fourth prevention strategy involves applying nutritional and chemical imbalance theories and looking into genetics and the like.

One of the strengths of the social-competency model is the assistance it provides to many other social problems such as teenage pregnancy, youth crime, or living with a chemically dependent parent.

The concern I have about this approach is, first, and perhaps most significant, the emphasis on the nation's youth. I think it is a strategic public policy mistake to focus all of our prevention resources exclusively on young people.

I believe adolescence is but one high-risk time. At a minimum, there are two others: the mid-40s and the mid-60s.

I am aware of no longitudinal studies that indicate this is true: that if I help clarify your values today, that will stop you from becoming an addict tomorrow. Studies correlate the two, but because things travel in a pack together, you cannot necessarily infer a cause-and-effect relationship.

A third concern I have about this model is its emphasis on alternative highs. I think we are better served, with our young people, when we legitimize lows, when we tell them it is part of the human condition to feel hurt, lonely, bored, frustrated, inadequate, and the like, and that there isn't always a cure, there isn't always a fix.

When we kneel at the altar of feeling good, I think implicitly we set kids up. I think sometimes in our prevention programs what we do is put Little League baseball in competition with cocaine. I think cocaine feels better.

Many kids say to me: 'Yes, Peter, it feels good to go camping, but it feels better to go camping stoned.' Well, that's wonderful values clarification; now, who's got the good retort?

Kids do not necessarily choose one or the other; I think there is a high likelihood in many instances of choosing both.

Digressing, I think it's a mistake we make in treatment, this emphasis on alternative highs rather than on legitimizing lows. That doesn't mean wallowing in lows, but rather saying it is okay to feel feelings that are uncomfortable.

I think one of the keys to long term recovery from chemical dependency, from my vantage point, is for a recovering addict or alcoholic to look this demon square in the eye: nothing ever again, ever, is going to feel as good as the chemical. Jogging isn't going to feel as good, racquetball isn't going to feel as good, therapy isn't going to feel as good, and, sex isn't going to feel as good. Nothing ever again is going to feel as good as the chemical.

That's the bad news.

The good news is that nothing ever again is going to create the havoc and pain in your life the chemical caused. I think when an addict or an alcoholic comes to a very quiet acceptance of that central fact, that is a cornerstone of long-term, contented sobriety.

A final criticism is that this prevention strategy is essentially borrowed from treatment and moved to the front-end of the continuum. That makes about as much sense to me as saying, 'Chemotherapy is a good treatment strategy for cancer, so let's give everybody in the country chemotherapy to prevent them from contracting it.'

The strategies you use to treat an illness may be very different, radically different, from the strategies you use to prevent the onset of that illness.

Those who hold to this belief face a difficult question: do communities, families, groups of people with low rates of addiction have more social competency than groups of people with high rates of addiction?

> ***'I believe adolescence is but one high-risk time. At a minimum, there are two others: the mid-40s and the mid-60s'***

Social-competency prevention consumes an inordinate amount of funds and, while there is a place for it, it should be balanced with other approaches to prevention.

The social-policy prevention model can be defined as 'the establishment and communication of clear and functional cultural and community rules, norms, standards, and consequences regarding alcohol and drug use and abuse.'

Which chemicals are legitimate, not necessarily legal, for the community, culture, or family to use? The clearer this gets answered, the fewer drug and alcohol problems we find. One of the reasons I think we have a high rate of addiction in (North) America today is the lack of clarity of this central question, and the best illustration of this is marijuana.

It is a quasi-legal, quasi-legitimate substance that I think sends mixed and confusing messages to everyone, including judges, probation and parole officers, parents, school administrators, teachers, and, perhaps most importantly, kids.

No one knows if this is a legitimate chemical or an illegitimate chemical. Further, no one knows if this is an illegal chemical or a legal chemical. The nebulous status that it enjoys, I think, maximizes the potential that it will get abused.

Tragically, from my vantage point, cocaine is becoming a quasi-legitimate substance. It is not quasi-legal, but it is clearly quasi-legitimate.

Depiction by the media has a profound influence. Cocaine has reached a certain degree of cultural legitimacy, while heroin has not.

> ***'You will see cocaine usage depicted . . . in a non-destructive sense . . . you will not see that in terms of heroin usage'***

You will see cocaine usage depicted by the media in movies and television in a non-destructive sense: people using it at a party, on a festive occasion, before they make love.

You will not see that in terms of heroin usage. I would challenge anyone to name any movie or any television show they have seen in which heroin has been involved and it is not used in a very negative context.

Heroin has no cultural legitimacy; cocaine has a measure of cultural legitimacy.

We in United States society have validated another reason for the use of chemicals — stress medication or escape. This is not to say that people throughout recorded history have not used chemicals for stress medication or escape. What I am saying is that there haven't been cultural sanctions for use of chemicals, such as 'happy hours' for alcohol use.

Two new strategies of prevention have developed over the past five years, but with promising results.

The first is the parents' movement. This movement started as a grassroots effort by parents concerned with adolescent alcohol or drug abuse; most of their concern was a result of problems in their immediate families.

More recently, they have become the dominant force in the prevention field, with the energetic support of the first lady (Mrs Ronald Reagan).

This movement has had a significant impact in a number of areas including highlighting the awareness of the general public to alcohol and drug abuse problems, encouraging more effective school-based programs, and most importantly, establishing much needed links among prevention, intervention, and treatment professionals and moving the US away from the dangerous libertarian view that drug abuse is an individual matter in which government has no role.

This movement, however, has been criticized — and I feel legitimately — as being simplistic in many of its solutions and having significant limitations on its ability to attract a broad cross-section of the population.

Another new prevention strategy is a nutritional/chemical/genetic imbalance approach to both prevention and treatment.

Many people have theorized that there is a genetic variable for addiction, or that dependency develops as a result of chemical imbalance or nutritional deficiencies which also can be passed from one generation to the next.

I am particularly concerned about early diagnosis and intervention. The US spends a great deal of money on treatment and significant sums on prevention but very little on diagnosis and intervention.

If we accept the fact that chemical abuse is progressively degenerative, like most other illnesses, the prognosis for success increases with early detection.

The largest gap in our delivery system is for a large group of kids who are marginal, episodic users of chemicals, who need more than social-competency prevention. Yet, I don't believe they need a structured inpatient or outpatient experience.

Looking into a crystal ball, I think the problem we are going to have increasingly is designer drugs. I think, in the next five years, we will develop the equivalent of bathtub gin in terms of cocaine, opiates, and the like, and that will enormously complicate the role of law enforcement."

> ***'I think in the next five years, we will be able to develop the equivalent of bathtub gin in terms of cocaine, opiates, and the like, and that will enormously complicate the role of law enforcement'***

THE BACK PAGE